_____ Scanned in QS1 _____ QS1 Immunization Record _____ Faxed Dr/HD

HPV Vaccine Consent Form

(Gardasil 9)

Must be 9 through 14 years of age (patients 9-12 must have a prescription)
Must remain in pharmacy for 10 minutes after injection

Schwieterman PHARMACIES & Compounding Center

PERSONAL INFORMATION

[PLACE RX LABEL HERE]

PATIENT PHONE:
( ) -

DATE OF BIRTH: / /

AGE:

☐ FEMALE ☐ MALE

COUNTY:

FAMILY DOCTOR:

MEDICARE/COMMERCIAL INSURANCE ID:

SCREENING QUESTIONS

1.	Are you currently sick with a fever?	☐ Yes ☐ No
2.	Do you have a severe (life-threatening) allergy to **yeast** or any component (or part) of this vaccine, including vitamins, amino acids, mineral salts, carbohydrates, amorphous **aluminum** hydroxyphosphate sulfate, sodium chloride, L-histidine, polysorbate 80, and sodium borate?	☐ Yes ☐ No
3.	Have you ever had a severe (life-threatening) reaction to a previous dose of any vaccine?	☐ Yes ☐ No
4.	For women: Are you breastfeeding, pregnant, or is there a chance you could become pregnant during the next month?	☐ Yes ☐ No

Please remain in the pharmacy for 10 minutes following the vaccination. If you leave, you are doing so against medical advice.

I have read or have had explained to me the information in the Vaccine Information Statement about human papillomavirus (HPV) vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of HPV vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request. I waive and release all claims I, or anyone claiming by or through me, now have or may hereafter acquire against Dr. James Schwieterman, MD, Schwieterman Pharmacies, and their respective directors, officers, employees, and agents for any damage or injuries if I, or the person named below for whom I am authorized to make this request, contact HPV, other diseases, or suffer any other adverse reactions following administration of this HPV vaccine. **I understand that I may be held responsible for charges that are not covered by my insurance. I understand that if I do not provide the proper insurance information I may also be held responsible for charges.** For Medicare Recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party that accepts assignment.

SIGN

SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE THE REQUEST (PARENT OR LEGAL GUARDIAN) **DATE**

----------FOR CLINIC/OFFICE USE ONLY----------

IMMUNIZER:			TITLE:	DATE OF IMMUNIZATION:
VACCINE/MFG/DOSAGE: Gardasil 9/Merck/0.5ml	LOT #:	EXP DATE:	SITE OF INJECTION: ☐ LA/IM ☐ RA/IM	VIS DATE: 12/2/2016
INSURANCE: ☐ Medicare ☐ Rx Coverage ☐ Major Med ☐ Cash ☐ _____			STORE:	

DOSE _____ of 2 (Dose 2 is given 6-12 months after Dose 1)

Updated Aug 2017