_____ Pt Chart _____ Impact SIIS _____ Faxed Dr/HD _____ Scanned in QS1

Meningococcal Vaccine Consent Form

(MCV4)

Must be 11 years of age or older (patients 11-12 must have a prescription)
Remain in the 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 formaldehyde, phosphate buffers, alcohol, ammonium sulfate, and amino acids?	☐ Yes ☐ No
3.	Have you ever had a severe (life-threatening) allergic reaction to a previous dose of any vaccine?	☐ Yes ☐ No
4.	Have you ever developed Guillain-Barre Syndrome within 6 weeks of receiving a vaccine?	☐ Yes ☐ No
5.	For women: Are you currently pregnant or breastfeeding?	☐ 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 meningococcal vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of meningococcal 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 meningitis, other diseases, or suffer any other adverse reactions following administration of this meningococcal 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:	VIS DATE: 3/31/2016

VACCINE/MFG/DOSAGE:	LOT #:	EXP DATE:	SITE OF INJECTION:
☐ Menactra/Sanofi/0.5ml (11 or older) ☐ Menveo/Novartis/0.5ml (11 or older)			☐ LA/IM ☐ RA/IM

INSURANCE:	STORE:
☐ Medicare ☐ Rx Coverage ☐ Major Med ☐ Cash ☐ _____	

Updated Aug 2016