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

Varicella (Chickenpox) Vaccine Consent Form

Must be 7 years of age or older (patients 7-12 must have a prescription)
Must remain in pharmacy for 15 minutes after injection

Schwieterman PHARMACIES' VACCINATION PROGRAM
Protecting Your Family's Health

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 or any type of infection including tuberculosis?	☐ Yes ☐ No
2.	Do you have a severe (life-threatening) allergy to any component (or part) of this vaccine, including sucrose, **gelatin,** sodium chloride, glutamate, sodium phosphate, potassium chloride, MRC-5 cells, EDTA, **neomycin**, and fetal bovine serum?	☐ Yes ☐ No
3.	Have you ever had a severe (life-threatening) allergic reaction to a previous dose of any vaccine?	☐ Yes ☐ No
4.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐ Yes ☐ No
5.	In the past 3 months, have you taken medications that weaken your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐ Yes ☐ No
6.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐ Yes ☐ No
7.	Have you received any vaccinations in the past 4 weeks?	☐ Yes ☐ No
8.	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 15 minutes following the vaccination. If you leave, you are doing so against medical advice.

I certify that I am: (a) the patient and at least 18 years of age or (b) the parent or legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of Schwieterman Pharmacies, to administer the vaccine I have requested above. I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above. I acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. I acknowledge that, depending upon my state's law, I may prevent the disclosure of my immunization information by the applicable Provider to the State Registry by using the opt-out form. The Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the Provider reporting my immunization information to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information as required or permitted by law. I voluntarily authorize and direct my healthcare provider at Schwieterman Pharmacies to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at Schwieterman Pharmacies, my Primary Care Physician, my insurance and/or state or federal registries, where required, for the purpose of treatment, payment or other healthcare operations. I further agree to be fully financially responsible for any cost sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service.

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: Varivax/Merck/0.5ml	LOT #:	EXP DATE:	SITE OF INJECTION: ☐ LA/SQ ☐ RA/SQ	VIS DATE: 8/15/2019
INSURANCE: ☐ Medicare ☐ Rx Coverage ☐ Major Med ☐ Cash ☐ _____			STORE: ☐ CL ☐ CW ☐ MIN ☐ NB ☐ SM ☐ WP	

Time Reconstituted: _____ Time Administered: _____ Diluent Lot #/Exp Date: _____/_____ Updated Aug 2019

DOSE _____ OF 2 (Dose 2 is given 3 months after Dose 1 if 12 YO & Younger; Dose 2 is given 4 weeks after Dose 1 if 13 YO & Older)