VACCINE CONSENT FORM

Lititz Apothecary
100 E Main St
Lititz, PA 17543
Ph: 717-626-2222 Fax: 717-626-7920

Appt Time: _____
MBI #: _____
BIN: _____
PCN: _____
ID: _____
RX Group: _____

PATIENT INFORMATION

☐ Male ☐ Female

First Name | MI | Last Name | DOB (MM/DD/YYYY)

Address | City | State | Zip

Phone | PCP Name/Group | Race | Allergies

VACCINE(S) REQUESTED

Vaccines	Lot/Exp	Dose	VIS	Vaccines	Lot/Exp	Dose	VIS
☐ Flu (5-64) Flucelvax/Afluria		0.5 mL	01/31/2025	☐ Moderna (12+) Spikevax		0.5 mL	01/31/2025
☐ Flu (65+) Fluad		0.5 mL	01/31/2025	☐ Moderna (5-11) Spikevax		0.25 mL	01/31/2025
☐ Shingles (50+) Shingrix		0.5 mL	02/04/2022	☐ Pfizer (12+) Comirnaty		0.3 mL	01/31/2025
☐ RSV (60+) mRESVIA		0.5 mL	01/31/2025	☐ Pfizer (5-11) Comirnaty		0.3 mL	01/31/2025
☐ Pneumonia (18+) Prevnar 20		0.5 mL	05/12/2023	☐ Tetanus (18+) Boostrix		0.5 mL	01/31/2025

☐ **Other Vaccine:**_____ **Lot:**_____ **Exp:**_____ **Dose:**_____ **VIS:**_____

Which arm would you like to receive vaccine(s) in: ☐ Left ☐ Right ☐ One in each arm

SCREENING QUESTIONS

1. Are are feeling sick today? (Fever, cough, shortness of breath, sore throat, congestion or runny nose) ☐ Yes ☐ No
2. In the past 28 days, have you been diagnosed with COVID-19, exposed to someone COVID-19, or received any vaccine or a TB test? ☐ Yes ☐ No
3. Do you have any allergies to medications, foods (e.g. eggs), latex, a vaccine component (e.g thimerosal, polyethylene glycol, etc.) or a serious reaction to vaccine in past (swelling, trouble breathing, fainting or seizure? If yes, please list what you are allergic to:_____ ☐ Yes ☐ No
4. During the past year, have you received a transfusion of blood or blood products, been given immune (gamma) globulin or an antiviral drug, or received COVID-19 antibody treatment? ☐ Yes ☐ No
5. Do you heart disease, lung disease, liver disease, brain/seizure/nervous system disorder, Guillain barre, kidney disease, metabolic disease (e.g., diabetes) anemia or other blood disorder or taking blood thinner? If Yes: _____ ☐ Yes ☐ No
6. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, herpes, or cold sores? If Yes: _____ ☐ Yes ☐ No
7. In the past 3 months, have you taken medications that weaken your immune system such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? If Yes: _____ ☐ Yes ☐ No
8. **For women:** Are you pregnant or is there a chance you could become pregnant during the next month? ☐ Yes ☐ No
9. **For TDap and adult TD**: Do you have a cut, injury, puncture or open wound that prompted you to get a vaccine? ☐ Yes ☐ No

CONSENT

I have read, or have had read to me, the written information regarding the vaccine(s) being administered. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and have received a copy of a current Vaccine Information Sheet. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Lititz Apothecary, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s). I certify that I am at least 18 years old and hereby give my consent to the pharmacists of Lititz Apothecary to administer the vaccine(s). If under 18 years old signature by parent or guardian is required. I agree to wait near the vaccination location for approximately 15 minutes for observation by the pharmacist.

Print Name | Signature | Date

INTERNAL USE ONLY

Immunizer Name | Immunizer Signature | Date