Genesis Pharmacies

2023-2024 VACCINE ADMINISTRATION CONSENT FORM

Genesis Pharmacy Locations
- ❒ Taylor St.
- ❒ Maysville
- ❒ New Concord
- ❒ Roseville

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First Name	MI	Last Name	Today's Date

Address	Ethnicity	Race

City	State	Zip	Phone #

Family Doctor	Weight (For Needle/Epipen Determination)	Age	Birthdate

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I WOULD LIKE TO RECEIVE THE FOLLOWING VACCINE(S):
❒ Flu (age 7+) ❒ Meningitis (age 14+) ❒ MMR (Measles, Mumps, & Rubella) (age 18+) ❒ Tdap (Tetanus, Diphtheria, & Pertussis-whooping cough) (age 14+) ❒ Td (Tetanus & Diphtheria) (age 14+)
❒ COVID-19 (age 12+) Complete Section D (in addition to Sections C & E)
❒ Pneumonia (age 19+): Pneumovax 23 ❒ Prevnar 20 ❒ Have you ever received a pneumonia vaccine?………..………..❒ Yes ❒ No If yes, please list which pneumonia vaccine and when: ____
❒ RSV (Respiratory Syncytial Virus) Did your healthcare provider recommend that you receive RSV vaccine? …………………..………..❒Yes ❒ No
❒ Shingrix (Shingles) (age 19+): Dose 1 ❒ Dose 2 ❒ Have you ever had chicken pox, shingles, or have you ever received the chicken pox vaccine (2 doses) ……...............................…...❒ Yes ❒ No

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1. Are you sick today?..❒ Yes ❒ No

2. Have you ever had a serious reaction after receiving a vaccination or an injectable medication?..❒ Yes ❒ No
If yes, please list vaccine/medication and reaction: ____________________-
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3. Do you have an allergy to any foods, medications, animals, or vaccine ingredients (e.g. eggs, latex, gentamicin, polymyxin, neomycin, Neosporin, kanamycin, barium, thimerosal, phenol, yeast, gelatin, formaldehyde, polyethylene glycol, polysorbate, etc.)? ....❒ Yes ❒ No
If yes, please list allergy:________________________________

4. Have you ever had Guillain Barré Syndrome (a type of temporary severe muscle weakness), seizures, brain disorder, or neurological

problems?...❒ Yes ❒ No

5. Have you received any vaccine within the last 28 days?..❒ Yes ❒ No
If yes, please list vaccine and date: ____________________

6. Do you have a condition that may weaken your immune system (e.g. cancer, transplant, HIV/AIDS, tuberculosis, etc.)?..❒ Yes ❒ No

7. In the past 3 months, have you taken any medications that may affect your immune system (e.g. chemotherapy, radiation treatments, steroids, methotrexate, azathioprine, 6-mercaptopurine, any other treatments for autoimmune diseases, or antivirals, etc.)?..❒ Yes ❒ No
If yes, please list medication and dosage________________________

8. In the past year, have you received a blood transfusion, blood products, or been given a medication called immune (gamma) globulin?.......❒ Yes ❒ No

9. Do you have a history of thrombocytopenia (a condition that causes you to have an abnormally low number of platelets in your blood)?....................❒ Yes ❒ No

10. Which arm(s) would you prefer the vaccine(s)?
Left Arm ❒ Right Arm ❒

11. For Women: Are you pregnant, breastfeeding, or considering becoming pregnant within the next 3 months?..❒ Yes ❒ No

1. Has it been at least 8 weeks since your most recent COVID-19 vaccine dose (if applicable)? ....❒ Yes ❒ No
2. Have you received your 2023-2024 COVID-19 vaccine already? ....❒ Yes ❒ No
3. Do you have a history of a non-severe, immediate (onset less than 4 hours) allergic reaction after administration of a previous dose of one COVID-19 vaccine type? ....❒ Yes ❒ No
4. Do you have a history of myocarditis or pericarditis 3 weeks after any COVID-19 vaccine ....❒ Yes ❒ No
5. Do you have a history of Multisystem Inflammatory Syndrome (MIS-C Or MIS-A)? ....❒ Yes ❒ No
6. Are you Immunocompromised? ....❒ Yes ❒ No

(if yes, complete next section)

Please answer questions below to provide your previous COVID-19 vaccination history	**Please check the following that apply to you:**
▪ Have you ever received a dose of any COVID-19 vaccine ❒ Yes ❒ No If Yes, which vaccine product have you received previously? ❒ Pfizer-BioNTech ❒ Moderna ❒ Janssen ❒ Novavax ❒ Another Product ▪ How many doses of COVID-19 vaccine were administered? ________________________	❒ Receiving active cancer treatment for tumors or cancers of the blood ❒ Received organ transplant and taking medicine to suppress immune system ❒ Received stem cell transplant within last 2 years and taking medicine to suppress immune system ❒ Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome) ❒ Advanced or untreated HIV infection ❒ Active treatment with medication(s) that suppresses immune system Please specify: ____

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I hereby give my consent to the eligible healthcare provider at Genesis Ambulatory Pharmacies, to administer the vaccine(s) that I have requested. I have read or had explained to me the CDC's most current Vaccine Information Statement or Emergency Use Authorization (EUA) Fact Sheet for the elected vaccine(s), and understand the risks and benefits associated. I understand that with all vaccinations there is a possibility of a complication or adverse reaction. I hereby fully hold harmless and release Genesis Ambulatory Pharmacies, its affiliates, director, and all employees from any and all liabilities which may arise from the administration of the requested vaccine. In addition, I acknowledge that I have had the opportunity to ask questions and that my questions were answered to my satisfaction. I understand that my information will remain confidential, but will be shared with state immunization registries or the State Health Division. I understand that the state registry may share this information with other healthcare providers. I understand that this information will not be released except as permitted or required by law. I authorize Genesis Ambulatory Pharmacies to submit a claim with respect to the above services, to Medicare, Medicaid, or any other contracted third party. I agree to be financially responsible for any copays, deductibles, or denied claims.
Following vaccine administration, I acknowledge that I need to remain near the vaccination location for approximately 15-20 minutes for observation.

→Patient Signature:___________________________________Date:_________________
(Parent/Legal Guardian Signature if patient is under age 18)

SECTION F: FOR PHARMACY USE ONLY

Vaccine	Vaccine Name	Lot Number	Manufacturer	Expiration Date	Dosage (mL)	Route/Injection Site	Date of VIS or EUA
						IM L / R Deltoid SQ L / R Arm	
						IM L / R Deltoid SQ L / R Arm	
						IM L / R Deltoid SQ L / R Arm	

****If sterile diluent/adjuvant is used, please list Lot Number/Manufacturer/Expiration Date___________________________**

****Signature & Title of Vaccine Administrator: ____Date: ____________________**

****Signature & Title of Vaccine Supervisor (if needed): ____Date: ____________________**