Pharmacy

Immunization Consent and Authorization
PNEUMOCOCCAL, FLU, SHINGLES, TDAP VACCINATION ONLY

Please print clearly

First Name:_____ **Last Name:**_____ **Date of Birth:**_____ **Gender:**_____

Home Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Email Address:_____ **Phone:**_____ **Home** ☐ **Cell** ☐

Primary Care Provider Name:_____ **Phone:**_____

Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

I want to receive the following vaccination(s):_____

1. Do you feel sick today? Yes No
2. Do you have any health conditions, such as heart disease, diabetes or asthma? Yes No
   If yes, please list: _____
3. Do you have allergies to latex, medications, food, or vaccines (examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, or thimerosal)? Yes No
   If yes, please list _____
4. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? Yes No
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis), or other nervous system problem? Yes No
6. **For women:** Are you pregnant or considering becoming pregnant in the next month? Yes No
7. Have you received any vaccinations or skin tests in the past eight weeks? Yes No
   If yes, please list: _____
8. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)? Yes No
9. Are you currently on home infusions, weekly injections such as Humira® (adalimumab), Remicade® (infliximab) or Enbrel® (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments? Yes No
10. Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks? Yes No
11. Have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin in the past year? Yes No

I have read the information above on the **PNEUMOCOCCAL, FLU, SHINGLES, TDAP** vaccination and wish to receive a vaccination. I consent to the vaccination being given to me by a pharmacist or pharmacy student under the supervision of a pharmacist, a nurse or student nurse under the supervision of a nurse, or other qualified healthcare professional. I have also read the CDC vaccine information statement(s) for the vaccination(s) and understand the risks and benefits of the vaccine(s).

I have had an opportunity to ask questions, all of which have been answered to my satisfaction, and hereby waive any and all claims for injury or damages arising out of or related to this vaccination and its administration that I (or anyone claiming on my behalf) may have against the Board of Regents of the University of Oklahoma, including, but not limited to, its Regents, employees, officers, directors, the OU College of Pharmacy, administering staff, pharmacists, student pharmacists, nurses, and student nurses. I understand that it is strongly recommended that I wait in the vaccination area for 15 minutes after administration of the vaccine for observation for possible related reactions.

I hereby authorize OU College of Pharmacy to furnish to my insurance carrier(s) information concerning this vaccination and related documentation and assign to the College of Pharmacy all payments for the vaccination services rendered to me.

Signature:_____ _____

(**Patient** or Legal Guardian – may be required to show proof of guardianship) Date

BELOW THIS LINE IS FOR CLINIC USE ONLY

Vaccine	Date Given	Manufacturer & Lot Number	VIS Edition Date	Site	Signature of individual administering vaccine
			2/24/15	L R	