Briarcliff Health Mart® PHARMACY

CLINIC					
ADMIN USE ONLY					
	BILLED		CASH		GRITS

IMMUNIZATION CONSENT FORM

*****All sections must be filled completely*****

PATIENT INFORMATION					
LAST NAME		FIRST NAME		M.I	
DATE OF BIRTH		GENDER	____ MALE	____ FEMALE	
ADDRESS				APT #	
CITY		STATE		ZIP	
HOME PHONE		CELL PHONE			

INSURANCE INFORMATION			
DO YOU HAVE ANY PRESCRIPTION INSURANCE?	☐ PRIVATE ☐ MEDICARE ☐ MEDICAID ☐ NO		
INSURANCE BIN #		PCN #	
GROUP #		MEDICARE / PRIVATE INSURANCE ID #	

OPTIONAL PRIMARY CARE PHYSICIAN INFORMATION *OPTIONAL*					
NAME					
ADDRESS					
CITY		STATE		ZIP	
PHONE		FAX			

VACCINATION	
VACCINE REQUESTED	☐ FLU ☐ PNEUMONIA ☐ SHINGLES ☐ MENINGITIS ☐ OTHER_____

CASE HISTORY AND LISTED CONTRAINDICATIONS

PLEASE ANSWER THE FOLLOWING QUESTIONS

ALL VACCINES

QUESTION	YES	NO	DON'T KNOW
1. Have you had a physical examination within the past year?	◯	◯	◯
2. Are you sick today?	◯	◯	◯
3. Do you have allergies to medications, eggs or other food, a vaccine component, latex or gelatin, thimerosal, or neomycin? If Yes, list allergies below	◯	◯	◯
4. Have you ever had a serious reaction after receiving a vaccination?	◯	◯	◯
5. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder?	◯	◯	◯
6. Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?	◯	◯	◯
7. Have you had a seizure, brain disorder, Guillain-Barre Syndrome or other nerve problem?	◯	◯	◯
LIVE VACCINES (ZOSTAVAX ONLY)			
1. In the past 3 months, have you taken any medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	◯	◯	◯
2. During the past year, have you received a transfusion of blood or blood products, or been given a immune (gamma) globulin or an antiviral drug?	◯	◯	◯
3. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	◯	◯	◯
4. Have you received any vaccinations in the past 4 weeks?	◯	◯	◯
If Yes, What Vaccines?	_____		

***** FORM CONTINUES ON PAGE 2 *****

PATIENT CONSENT

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 ('Ward'). I have received a copy of the applicable Vaccine Information Statement(s) and I have read the adverse reactions associated with the administration of vaccine(s). Furthermore, I consent to the administration of the vaccine(s) requested above to me or my Ward and acknowledge that, as a condition to administration of the vaccine(s), myself or my Ward must remain under observation of the administering pharmacist for a period of not less than 15 minutes. I understand that a copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about the immunization(s). I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization(s) or the receipt of the immunization(s) by the person named above for whom I am the Ward. My medical record, may be shared with my primary care provider or other healthcare provider and the medical record of my Ward may be shared with his/her primary care provider or other healthcare provider. I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives and assigns, hereby release Briarcliff Pharmacy and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt by my Ward of this or these immunization(s). Neither Briarcliff Pharmacy nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccine(s) described above. I authorize Briarcliff Pharmacy to (a) notify me or my Ward's primary care provider of the vaccine administered and to provide same with copies of all vaccination records; (b) to enter my or my Ward's vaccine information on the Georgia Registry of Immunization Transactions; and (c) make any other disclosures required by law. Briarcliff Pharmacy will use and disclose my personal and health information or the personal and health information of my Ward, to receive payment of the care provided, and for other health care operations. Healthcare operations include those activities performed to improve the quality of care. I acknowledge that I have received a copy of the Notice of Privacy Practices.

For Patients receiving Live Vaccines only: I further certify that I have read the list of contraindications to the vaccine(s) set forth above and neither me or my Ward have a contraindication to the vaccine[s] to be administered.

PATIENT / LEGAL GUARDIAN SIGNATURE_____

PRINT NAME _____**DATE**_____

!!! PHARMACY USE ONLY !!!

ADMINISTRATIVE RECORD

1	**VACCINE**		**EXP DATE**		**VIS VERSION/DATE**		
	DATE ADMINISTERED		**MANUFACTURER**			**LOT #**	
	DOSAGE		**ROUTE OF ADMIN**		**DATE M.D NOTIFIED**		
2	**VACCINE**		**EXP DATE**		**VIS VERSION/DATE**		
	DATE ADMINISTERED		**MANUFACTURER**			**LOT #**	
	DOSAGE		**ROUTE OF ADMIN**		**DATE M.D NOTIFIED**		
3	**VACCINE**		**EXP DATE**		**VIS VERSION/DATE**		
	DATE ADMINISTERED		**MANUFACTURER**			**LOT #**	
	DOSAGE		**ROUTE OF ADMIN**		**DATE M.D NOTIFIED**		

ADMINISTERING PHARMACIST INFORMATION

NAME & TITLE		**LICENSE #**	
PHARMACY INFORMATION	**Briarcliff Pharmacy** **2724 Clairmont Road** **Atlanta, GA 30329** **(404) 728-0092**		

ADVERSE EVENTS/ COMPLICATIONS & NOTES

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REPORT ALL ADVERSE REACTIONS TO THE FEDERAL VACCINE ADVERSE EVENT REPORTING SYSTEM

