Immunization Consent Form

Valu Drug Pharmacy

201 E Pioneer Ave Montesano WA, 98563

Phone #: 360-249-4444

Vaccine to be administered:_____

Payment: Please mark which you need billed or if you are paying cash

___Medicare ___Insurance ___Cash

Personal Information:

Name:_____

First Middle Last

Address:_____

Street City State Zip

Birthday:_____Phone Number:_____

Primary Care Doctor:_____ Phone:_____

Precautions and Contradictions (Please circle yes or no for each question)

1. Are you sick today **YES NO**
2. Do you have any allergies to medications, food, or vaccines? **YES NO**
   Allergies:
3. Have you ever had a serious reaction after receiving a vaccination? **YES NO**
4. Do you have a long term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease, anemia or other blood disorder? **YES NO**
5. Do you have cancer, leukemia, AIDs, or any other immune system problem? **YES NO**
6. Do you take cortisone, prednisone, other steroids, anti-cancer drugs, or have you had X-Ray treatments? **YES NO**
7. Have you had a seizure, brain, or nerve problem? **YES NO**
8. During the past year have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? **YES NO**
9. For women- are you pregnant or is there a chance you could become pregnant during the next month? **YES NO**
10. Have you received any vaccinations in the past 4 weeks? **YES NO**
11. Are you allergic to latex? **YES NO**
12. Are you allergic to eggs? **YES NO**

Consent for services:

I understand the benefits and risks of vaccination and I have had the chance to ask questions. I request the vaccination be given to me or the person named above for whom I am authorized to sign.

X_____ Date:_____

Signature of person to receive vaccine(parent/guardian)

Mothers Maiden Name:_____ Race/Ethnicity:_____