FOR PHARMACY USE (DATE/TIME/INITIALS)
GRITS: _____
FAXED:_____

Immunization Consent Form

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	MI	GENDER (M/F)	BIRTH DATE (MM/DD/YY)
ADDRESS	CITY	STATE		ZIP
10-DIGIT PHONE NUMBER	MEDICARE ID NUMBER	MOTHER'S MAIDEN NAME		
PRIMARY CARE PHYSICIAN	PRIMARY CARE PYSICIAN PHONE/FAX			VACCINE REQUESTED

CASE HISTORY AND LISTED CONTRAINDICATIONS (Please circle YES, NO, or DON'T KNOW for each question)

ALL VACCINES

1. Have you had a physical examination within the Past year?.....YES NO DON'T KNOW
2. Are you sick today?.....YES NO DON'T KNOW
3. Do you have allergies to medications, eggs or other food, a vaccine component, or latex?.....YES NO DON'T KNOW
   If yes list allergies_____
   _____
   _____
4. Have you ever had a serious reaction after receiving a vaccination?.....YES NO DON'T KNOW
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? .....YES NO DON'T KNOW
6. Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?.....YES NO DON'T KNOW
7. Have you had a seizure, brain disorder, Guillian-Barre Syndrome or other nerve problem?.....YES NO DON'T KNOW

LIVE VACCINES

8. 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?.....YES NO DON'T KNOW
9. 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 .....YES NO DON'T KNOW
10. For women: Are you pregnant or is there a chance you could become pregnant during the next month?.....YES NO DON'T KNOW
11. Have you received any vaccinations in the past 4 weeks? .....YES NO DON'T KNOW
    If yes, what vaccines? _____
    _____

I have read or have had explained to me written information about the vaccine listed below. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine being administered and authorize the administration of the vaccine to me or the person named below for whom I am authorized to make this decision.

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.

_____ _____
SIGNATURE/LEGAL GUARDIAN DATE OF VACCINATION/DATE VIS GIVEN

_____
PRINT

FOR PHARMACY USE ONLY:

VACCINE NAME		MANUFACTURER	
LOT NUMBER	EXPIRATION DATE	SITE OF INJECTIONS (circle one) RIGHT ARM LEFT ARM	ROUTE OF INJECTION (circle one) IM SQ
DATE ADMINISTERED			
VACCINE ADMINISTRATOR (circle one) ALEX TUCKER NATALIE FONTAINE JODIE TUCKER MEAGAN MILLS CALEB RUSH KARALYN DEFRANCESCO PHARMACIST INTERN BRADLEY GAY OTHER _____		TITLE (circle one) PHARMACIST PHARMACIST INTERN PHARMACY TECHNICIAN	
SIGNATURE			

2409 Hwy 17
Richmond Hill, GA 31324
(912) 756-3331

RICHMOND HILL PHARMACY
at Towne Center

2409 Highway 17 South, Richmond Hill, GA 31324
Phone & Fax: (912)756-3331
www.richmondhillpharmacy.com

Date: _____

Dr: _____,

A mutual patient has recently received one or more vaccinations at our pharmacy. This letter serves to notify you which vaccination he/she has received. All vaccinations are reported to the Georgia Registry of Immunization Transactions and Services (GRITS) database. Please call if you have any questions.

Regards,

Alex Tucker, PharmD
Jodie Tucker, PharmD
Caleb Rush, PharmD
Meagan Mills, PharmD

Patient Name: _____ DOB:_____

Vaccine Received:

- ☐ Tdap (Tetanus, Diphtheria, and Pertussis)
- ☐ Influenza (inactivated)
- ☐ HPV (select one: Cervarix, Gardasil, Gardasil 9)
- ☐ Other: _____
- ☐ Recombinant Herpes Zoster (SHINGRIX)
- ☐ Herpes Zoster Live (ZOSTAVAX)
- ☐ Pneumococcal Vaccine (_____)

Date Administered:_____

Administered by:

- ☐ Alex Tucker, PharmD
- ☐ Jodie Tucker, PharmD
- ☐ Caleb Rush, PharmD
- ☐ Meagan Mills, PharmD
- ☐ Pharmacy Intern
- ☐ Other:_____

Prescriber:_____ Fax:_____