Pharmacy Vaccine Administration Consent Form

Patient Information

Full Name

Date of Birth

Address

Phone

Email

Vaccine Information

Vaccine Name

Manufacturer

Lot Number

Expiration Date

Health Screening

☐ History of severe allergy (anaphylaxis) to vaccine or component

☐ Currently feeling sick

☐ Pregnant or breastfeeding

Other medical conditions or allergies

Consent and Authorization

I acknowledge that I have read, or have had explained to me, information about the vaccine. I have had a chance to ask questions and my questions were answered to my satisfaction.

I consent to receive the vaccine as indicated above.

Patient/Guardian Signature

Date

Pharmacist Name

Pharmacist Signature

Date