VACCINE CONSENT FORM

Hayat Pharmacy
807 W Layton Ave, Milwaukee, WI
414-269-2530

Name: _____**Gender:**_____ **Date of Birth:** _____
Address: _____
Phone: _____ **Email:** _____
Race: ☐American Indian ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White ☐Other:
Ethnicity: ☐Hispanic ☐Non-Hispanic

Screening Questionnaire

1.	Are you sick today?	Yes	No
2.	***If receiving COVID vaccine*:** Have you previously received a dose of the COVID-19 vaccine? Last date received: _____ Doses Received: 1 2 3	Yes	No
3.	In the past 14 days have you had contact with a confirmed COVID-19 patient?	Yes	No
4.	Do you have any allergies to medications, food, eggs, yeast, vaccine components or latex? If yes, list here: _____	Yes	No
5.	Have you ever had a serious allergic reaction after receiving a vaccine (including a previous dose of the COVID-19 vaccine)?	Yes	No
6.	Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	Yes	No
7.	Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder?	Yes	No
8.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, herpes, or cold sores?	Yes	No
9.	In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	Yes	No
10.	Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	Yes	No
11.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug (including acyclovir, famciclovir, valacyclovir?	Yes	No
12.	***For women:*** Are you pregnant or is there a chance you could become pregnant during the next month?	Yes	No
13.	Have you received any vaccinations or a TB skin test in the past 4 weeks?	Yes	No
14.	Do you have a history of fainting, particularly with vaccines?	Yes	No
15.	***For Tdap and adult Td**:* Do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?	Yes	No
16.	***For Zoster:*** Have you had a past reaction to gelatin or triple antibiotic ointment?	Yes	No

Insurance Information

ID number:		RxPCN:
RxBIN:	RxGroup:	Last 4 of SSN:

I have read, or have had read to me, the written information regarding the vaccine(s) marked above. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and have received a copy of a current Vaccine Information Sheet for each vaccine I am receiving today. I, on behalf of myself, my heirs, executors, and personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Hayat Pharmacy, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) marked above. I certify that I am at least 18 years old and hereby give my consent to the pharmacies of this Mutual Member Drug Store to administer the vaccines marked above. If under 18 years old signature by parent or guardian is required. I AGREE TO WAIT NEAR THE VACCINATION LOCATION FOR APPROXIMATELY 15 MINUTES FOR OBSERVATION BY A HAYAT PHARMACIST.

Patient/Guardian signature: _____ **Date:** _____

THIS SECTION IS FOR HEALTHCARE PROVIDER ONLY

Vaccine/Manufacturer	Lot #	Exp Date:	Dosage	Deltoid:	Date of VIS	Dose #
				L or R		
				L or R		

Administered By: _____ Date: _____
Supervising Pharmacist: _____