Hayat Pharmacy Vaccine Consent Form
www.HAYATRX.com

Name (Please Print):	Sex:	Date of Birth:	Medicare ID / Last 4 SSN:

Street Address, City, State, Zip	Phone Number:

Rx BIN:	RxPCN:	RxID:	RxGroup:

1. Which vaccine(s) are you requesting today?					
		COVID-19		Hepatitis A and B
		Influenza (Flu shot)		Measles, Mumps and Rubella (MMR)
		Respiratory Syncytial Virus (RSV)		Meningitis
		Shingles		Chicken Pox (Varicella)
		Pneumonia		Typhoid
		Tetanus, Diphtheria , Pertussis (Tdap or Td)		Polio
		Human Papillomavirus (HPV)		

2. Are you sick today?	
3. Have you ever had a serious reaction after receiving a vaccination?	
4. Do you have severe allergies to any medications, food, vaccine or latex?	
5. Have you had a seizure or nervous system problem? (e.g. Guillain-Barré)	
6. Are you pregnant or is there a chance you could become pregnant during the next month?	
7. Have you ever felt dizzy or faint before, during, or after a shot?	
8. Are you anxious about getting a shot today?	
Answer questions 9-10 only for Shingles Vaccine:	
9. Do you currently have Shingles?	
10. Have you ever had Shingles, Chickenpox or received Chickenpox Vaccine?	
Answer questions 11-12 only for Pneumonia / RSV Vaccine:	
11. Do you have alcoholism, or do you smoke cigarettes?	
12. Do you take steroids, anticancer drugs or other immunosuppressants?	
Answer question 13 only for COVID:	
13. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	
Answer questions 14-15 only for MMR:	
14. Do you have long-term health problems? (e.g. Heart/liver/lung/kidney disease, diabetes, asplenia, CSF leak, cochlear implants or blood disorder)	
15. Do you have cancer, HIV, organ transplant, autoimmune/inflammatory disease or any other immune system problems?	

I have read, or had explained to me, the Vaccine Information Statement (VIS) and/or the FDA Emergency Use Authorization Fact Sheet for the COVID-19 vaccine. I understand the benefits and risks of this vaccine and ask that the vaccine be given to me or the person for whom I am authorized to make this request. I have been made aware of the appropriate time I am expected to be monitored for post-vaccination reactions based on my risk factors. I hereby attest to the best of my knowledge that I am currently eligible to receive the vaccine(s) requested. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination described. I request the vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purposes such as reporting to WIR (Wisconsin Immunization Registry).

Signature of Recipient (Parent or Guardian): **Date:**

Pharmacy Use Only

Vaccines given:	Manufacturer:	Lot & Exp	Route & Site: IM - Deltoid	WIR history checked	
				VIS given to patient	
				Entered in WIR	
				Paid	
				Date of Administration:	
Signature: Registered Pharmacist / Registered Nurse					