Wynn's Pharmacy 536 S 8th Street Griffin, GA 30224

Immunization Consent Form

Patient Name		**DOB**		**Gender**	☐ **Male** ☐ **Female**
Address		**City, State, Zip**			
Phone Number	**( )**	**Social Security Number**			
Ethnicity (choose only 1) Not Hispanic Hispanic Unknown		**Race (choose one)** Asian/Polynesian Black Multiracial White Native American/Alaskan Unknown			
Primary Physician		**Vaccine Requested**			

Case History and Contraindications *(Please place a ✓ in the correct column for each question.)*

Please answer the health questions below:	Yes	No	Don't Know
1. Have you had a physical examination in the past year?			
2. Are you sick today or currently in an isolation period for COVID-19?			
3. Have you had a positive COVID-19 test in the last 90 days and received convalescent plasma?			
4. Do you have allergies to medications, eggs or other foods, a vaccine component, latex or polyethylene glycol?			
5. Have you ever had a serious reaction after receiving a vaccination or IV injectable medications?			
6. Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?			
7. Are you currently receiving anticoagulation therapy, or do you have any type of bleeding disorder?			
8. Do you, and/or anyone you live with or take care of, have a weakened immune system?			
9. Have you had a seizure, brain disorder, Guillian-Barre Syndrome or other nerve problem?			
10. In the past 3 months, have you, or anyone you live with or take care of, taken any medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anti-cancer drugs, or had x-ray treatments?			
11. During the past year, have you received a transfusion of blood or blood products, or been given an immune (gamma) globulin or an antiviral drug?			
12. Have you received any vaccines within the past 2 weeks? If yes, list vaccines below. _____			
13. Do you have an adrenaline auto injector (EpiPen) for severe allergic reactions?			
14. Are you pregnant, or is there a chance you may become pregnant in the next four weeks?			
15. Are you currently breastfeeding?			
16. Have you had a Mastectomy? If yes, which side was your Mastectomy on? _____			

I certify that I am the Patient (or Legal Guardian) of the person getting the Vaccination. I have been allowed to ask questions about side effects, possible reactions and benefits of the product and my questions were answered to my satisfaction. I waive all liability that might occur after the Vaccine is given. Medical records regarding this Vaccine may be shared with the Primary Physician and with the State Registry and any other health related entity as allowed by law. I have been offered a Vaccine Information Statement and any related materials regarding the Vaccination. For COVID vaccination, I have been given a copy and have read the Emergency Use authorization (EAU) or the Vaccine Information Statement (VIS) for the COVID-19 Vaccine. I agree that I have been given adequate time after the Vaccination for observation of any adverse reactions. By signing below I agree that I understand the benefits outweigh any risks involved by getting the chosen Vaccination. I Patient (or Legal Guardian) am of age and of reasonable health and have answered all questions to the best of my knowledge. Wynn's Pharmacy and staff have no liability or responsibility for any claims arising from any Vaccine given. For those receiving the COVID-19 vaccination, my signature acknowledges that I was advised to remain on site for 15 minutes after receiving the vaccine. Those with previous anaphylactic reactions should stay for 30 minutes.

_____ _____

Signature of Patient or Legal Guardian Date

Pharmacy Use Only Below Line

Vaccine	MFR	Lot	Expiration	Dosage	Route	Site	EUA/VIS

_____.

Signature of Administrator