



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: _____