What to consider when getting a flu shot-

For patients: The following questions will help us determine which vaccines you may be given. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider. A consent form will need to be completed at the time of your flu shot. These questions will help you prepare.

1. Are you sick today?
2. Do you have allergies to medications, foods or any vaccine? (i.e. gelatin, eggs, latex, etc.)
3. Have you ever had a serious reaction after receiving a vaccination?
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?
6. 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?
7. Have you had a seizure or a brain or other nervous system problem? (i.e. Guillain-Barre Syndrome, encephalopathy)
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?
10. Have you received any vaccinations in the past 4 weeks?
11. Are you currently taking anticoagulant or antiplatelet medications? (Coumadin, warfarin, aspirin, Plavix, Lovenox, etc.)
12. Are you current on all your vaccinations? (Pneumonia, Shingles, TdaP, etc.)

Hy-Vee pharmacy

Informed Consent to Receive Vaccines

Name: _____ **Date of Birth**_____ **Male/Female**

Street: _____ **City**_____ **Zip** _____

Phone: _____ **Primary Care Provider (optional):** _____

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, foods or any vaccine? (i.e. gelatin, eggs, latex, etc.)	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (i.e., diabetes), anemia, or other blood disorder?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, history of lymph node removal (i.e. mastectomy) or any immune system problem?	☐	☐	☐
6. 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?	☐	☐	☐
7. Have you had a seizure or a brain or other nervous system problem? (i.e. Guillain-Barre Syndrome, encephalopathy)	☐	☐	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune globulin or an antiviral drug?	☐	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
11. Are you currently taking anticoagulant or antiplatelet medications? (Coumadin, warfarin, aspirin, Plavix, Lovenox, etc.)	☐	☐	☐
12. Are you current on all your vaccinations? (Pneumonia, Shingles, TdaP, etc.)	☐	☐	☐
13. Where would you like the vaccine administered? (please choose one location) Adults: Left Arm Right Arm Children: Left Arm Right Arm Left Thigh Right Thigh			

I have read, or have had read to me, the Vaccine Information Statement (VIS) indicated below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s) marked above. I authorize the information to be forwarded to my primary care physician, authorizing physician and state registry, if applicable. I agree to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I hereby release Hy-Vee, its officers, employees and agents from any and all liability that might arise from this vaccination on behalf of myself, my heirs and personal representatives.

_____ _____

Patient or Guardian Signature **Date**

Authorized Pharmacist (And intern if applicable) (Administers vaccine and reviews questionnaire)	Admin Date/ VIS given to patient date	Vaccine	Vaccine Lot	#Exp Date	Manufacturer	VIS Date	Dose (mL)

Admin Site: Right—Left–Arm—Thigh—Nasal—SQ—IM **Adverse Reaction (attach VAERS form) Notification to Primary Provider** _____ **(date)**