Davenport Pharmacy
525 Morgan St
Davenport, WA 99122
509-725-1151

Vaccine Consent & Release:

Patient Name:_____ **Date of Birth:**_____ **Gender**: [ ] M or [ ] F

Address:_____ **City**_____ **State**_____ **Zip**_____

Phone:_____ **Email:**_____

Ethnicity: [ ] White [ ] America Indian [ ] Asian [ ] African American [ ] Hispanic/ Latino [ ] Other

What Vaccine(s) are you requesting today? (Circle)**:** Pharmacist will write vaccine name & dose

Flu_____ IM Dose:_____ Pneumonia_____ IM Dose:_____

Shingles_____ IM Dose:_____ RSV_____ IM Dose:_____

Tdap_____ IM Dose:_____ Covid_____ IM Dose:_____

List any known allergies:_____

List any known medical conditions:_____

Please answer the following questions:	**Yes**	**No**	**I Don't Know**
1. Are you sick today? (ex. Cold, fever, acute illness)			
2. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease, anemia, or other blood disorder?			
3. Do you have cancer, leukemia, aids, or any other immune system problem?			
4. For women: Are you pregnant or is there a chance you could become pregnant during the next month?			
5. Have you ever had a reaction after receiving a vaccine, including feeling faint or dizzy?			

Have you had other vaccines in the past 4 weeks? If Yes, what was given and when:

_____

Please read ALL the following statements, if consent is given, please sign and date below.

1) I have been provided with the Vaccine Information Sheet (VIS) and / or information regarding the vaccine I am receiving and the provider's Notice of Privacy Practices which may be provided at my request.
2) I understand the benefits and risks of the vaccine and have had the chance to ask questions regarding it. I voluntarily assume full responsibility for any reactions that may result.
3) I request the vaccine be given to me and authorize and direct Davenport Pharmacy to use or disclose my health information during the term of this authorization to Dr. Kathy Altman, the collaborative drug therapy protocol physician, my Primary Care Physician (PCP), my insurance plan, and/or state registries where required for purposes of treatment, payment or other health care operations. This only allows this provider to disclose the following medical records: only documents related to the vaccination received today. I understand that I may refuse or revoke this authorization at any time.
4) I request that payment of authorized benefits and/or authorized Medicare benefits be made on my behalf to Davenport Pharmacy for any services or items furnished to me. I assign and transfer to this provider any and all rights to receive insurance benefits otherwise payable to me for products of services provided by this provider. I understand that I am financially responsible to this provider for any charges not covered by health care benefits. I am responsible for the entire bill or balance of the bill as determined by this provider or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility explained above for all payment for products and services provided to me.
5) I authorize the release of all records to act on this request, and I request that payment of benefits be made on my behalf.

Signature_____ **Date**_____

Prescriber_____ **Date**_____

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Vaccine Administration Record:

*****To be Completed by Pharmacy Staff*****

VIS Published Date: _____
Administration Site: _____
Immunizer: _____
Administration Date: _____

Affix Label Here

VIS Published Date: _____
Administration Site: _____
Immunizer: _____
Administration Date: _____

Affix Label Here

VIS Published Date: _____
Administration Site: _____
Immunizer: _____
Administration Date: _____

Affix Label Here