NEW HOPE PHARMACY AND WELLNESS LLC
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Vaccine Consent Form

Name of Individual to be immunized_____

Address (St) _____City/State_____Zip_____

Phone#_____Date of Birth_____M/ F_____

Insurance: _____ ID#_____Medicare # _____

RxBIN _____RxGroup _____RxPCN_____SSN_____

Please answer the following:

Are you sick today?	Yes _____	No _____
Are you allergic to chicken, eggs, or egg products?	Yes _____	No _____
Have you ever had an allergic reaction to any Vaccine?	Yes _____	No _____
Are you pregnant, or think you may be?	Yes _____	No _____
Do you have a blood clotting disorder or are you taking	Yes _____	No _____
Blood thinning medication?	Yes _____	No _____

Acknowledgement:

I am at least 18 years of age. I have read or have had explained to me the _____ vaccine (the vaccine from here on): "What you need to know" vaccine information sheet. I have been given the opportunity to as a NHP professional concerning the vaccine, including the risks and benefits of receiving the vaccine. I understand the benefits and risks of the vaccine and request that it be given to me.

I affirm that I am not allergic to eggs, chicken, thimerosal, albumin products or a previous dose of the vaccine. I do not have a history of Guillain-Barre' Syndrome (GBS). I understand my medical care provider may submit this immunization information to the state immunization registry.

Release of Liability:

I have read and I understand the acknowledgements set forth above, and I hereby release the NHP and their affiliated entities, and all their agents, employees, trustees, and representatives, from any and all liability which may arise from the vaccination and/or from the information provided to me concerning such vaccination.

Consent to the Vaccination:

I have read and I understand the information set forth in this form. Based on that understanding, I hereby CONSENT to an _____ vaccination provided to me by NHP.

Signature of Recipient of the Vaccination _____ Date _____

If signed by someone other than recipient (Parent/Caretaker), please indicate name and relationship.

Name _____ Relationship_____Date_____

For Official Use Only

Vaccine name_____ Vaccine Lot # _____ Exp: _____Date: _____

Site of injection: R _____ L ___ (Arm/Thigh) _____Volume_____Initials of official:_____

Vaccine name_____ Vaccine Lot # _____ Exp: _____Date: _____

Site of injection: R _____ L ___ (Arm/Thigh) _____Volume_____Initials of official:_____