

# Quick Care Pharmacy

350 Sunset Drive  
Grenada, MS 38901

**GES (4-5)**

662-307-2221 phone  
662-307-2438 fax

## Vaccination Administration Record (VAR) Informed Consent for Vaccination

Section A. Name: \_\_\_\_\_ Birthday: \_\_\_\_\_

Address: \_\_\_\_\_ Gender: (Circle one)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Male Female

Phone Number: \_\_\_\_\_ Known allergies: \_\_\_\_\_

Insurance Type: \_\_\_\_\_ Policy Number: \_\_\_\_\_

What are you here for today? (Circle One) Vaccine Flu Pneumonia Other: \_\_\_\_\_

Section B. Please answer all the following questions to determine eligibility for vaccinations.	YES	NO
1. Do you have fever, diarrhea, or have you vomited today?		
2. Have you ever had a serious reaction after receiving a vaccination?		
3. If you are age 65 or older, have you ever had a pneumonia vaccine?		
4. For women, Are you pregnant or considering becoming pregnant in the next month?		
5. Do you have any known allergies to medication, foods, vaccines? (examples: Eggs, Gelatin, Gentamicin, Streptomycin, Neomycin, Thimerosal, Baker's Yeast)		
6. Have you ever had a seizure disorder, brain disorder, Guillain-Barre Syndrome (condition that causes paralysis) or any other nervous system disorder?		

*Section C. I hereby give my consent to the pharmacist at Quick Care Pharmacy to administer the vaccine(s) I have requested above. I understand that it is not possible to predict any possible side effects or complications associated with receiving the vaccine(s) and I have been given the opportunity to ask any questions pertaining to the vaccine(s). I authorize Quick Care Pharmacy to release my vaccination record to healthcare professionals to receive payment from my insurance and report to the MS Department of Health if required.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Person receiving vaccine (or parent/guardian if minor))

Vaccination Record			
Vaccine	Lot #	Exp Date	Site of Injection
Fluzone High Dose	UI985AC	03/22/2019	
Fluzone QUAD	UI997AB	06/30/2019	