Pharm A Save Monroe
17788 147th ST SE
Monroe, WA 98272

Vaccine Consent Form

Information about the person to receive the vaccine(s) (PLEASE PRINT):

Name: _____Birthdate:_____

Address_____Phone_____

City:_____ State:_____ Zip:_____

Allergies_____

Chronic Conditions _____

Primary Care Physician_____

Requested Vaccines (please check)
__ Influenza __ Prevnar 13 __ Pneuovax 23 __ Zostivax (addition form needed)
__ Tdap __ MMR __Oral Typhoid

__ Engerix (Hep B) __ Twinrix (Hep A&B) Other _____

"I have read or have had explained to me the information in the CDC Vaccine Information Statement(s). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of this/these vaccine(s) and ask that the vaccine(s) be given to me"

_____ _____
Signature Date

☐ Check here if you do not wish to have your primary physician notified of this vaccination.

****For Pharmacy Use****

	Vaccine #1	Vaccine #2	Vaccine #3
Date Administered			
Vaccine			
Manufacturer			
Lot Number			
Expiration Date			
Site & Route of Inj			
Date of VIS			

_____ _____
Generic Substitution Permitted **Dispense As Written**