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Do you have any allergies to medications, food or vaccines? If yes, please list: Have you ever had a serious reaction or fainted after receiving a vaccination (e.g. Guillain-Barré Syndrome)?												
Have you ever had a serious reaction or fainted after receiving a vaccination (e.g. Guillain-Barré Syndrome)? For women: Are you pregant or are you considering becoming pregnant in the next month? Have medical condition(s) or take medication(s) that weaker your immune system? (e.g. cancer, leukemia, HIV, active shingles, oral steroids, anticancer or antiviral please indicates which vaccine(s) you would like amount information about 20 Heapatits a, MMR (Measles, Mumps, subleil) and Travel Vaccines or Inhibitodod Vaccine Please indicates which vaccine(s) you would like an assessment done of potential vaccination gaps or needs **Test No-Patients Signature of PNEUMONIA vaccine? If yes, when and what kind(s)? Patients 19 and older of immunocompromised: Have you ever received the SHINGLES vaccine? If so, what date(s): Patients 19 to 59 years old: Have you received a hepatitis 8 vaccine series? Patients 19 to 59 years old: Have you received a hepatitis 8 vaccine series? Patients aged 11 to 23: Have you received a meningitis vaccine? Patients aged 11 to 23: Have you received a meningitis vaccine? How many years has it been since your last TETANUS vaccine? Yes SUCCINES ONLY (Chickenpox, cholera, intransast flu, MMR* II, rotsvirus, oral typhoid, and yellow fever) Ves SUCCINES ONLY (Chickenpox, cholera, intransast flu, MMR* III, rotsvirus, oral typhoid, and yellow fever) Ves SUCCINES ONLY (Chickenpox, cholera, intransast flu, MMR* III, rotsvirus, oral typhoid, and yellow fever) Ves SUCCINES ONLY (Chickenpox, cholera, intransast flu, MMR* III, rotsvirus, oral typhoid, and yellow fever) Ves SUCCINES ONLY (Chickenpox, cholera, intransast flu, MMR* III, rotsvirus, oral typhoid, and yellow fever) Have you received any vaccination in the past 4 weeks? If yee, please list: Journing the past yeer, have you received as bood transastions, hot populations, prophysical orange of the water	+ '-		·	- Jane Pak								
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Check all that apply to you. Asthma or lung disease				, ,		ome)?						-
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Signature of Patient or Parent/Guardian of Minor Patient (put relationship to minor) Printed Name Below for Pharmacy Use Only: WA ONLY: Substitution Permitted: Vaccine Name Lot # Expiration Date Manufacturer Dose (ml) Dose # Route Site (circle) VIS/EUA Put OVID-19() Flu () Shingrix® GSK O.5 GSK O.5 IM R / L Deltoid 2/4/202 Prevnar 20® Pfizer O.5 IM R / L Deltoid R / L R / L R / L R / L R / L	signature belovertsons Compa littly criteria for t ors, employees, eceiving a flu va mit a claim for ent; 3) I am of le iveness of the v ience any side e , 1 should remail ne. 7) I have read ions have been bility and Accou	w, I consent to the administration nies or one of its affiliated pharm the vaccination (if any); if I am the, and agents from all liability, including a more of the second of the secon	pacies and to be contacted at the number e parent/guardian of the minor patient, I a uding acts of omission or commission, res mber 1st, I am either a parent signing on b Medicare or any other contracted third-pate te this consent form or I am the parent/gu about potential side effects after vaccinal area for observation for 15 minutes unless 30 minutes after the vaccination. If I leave accine Information Statement(s) ("VIS") or derstand the benefits and risks of the vac- cination, including any vaccination granted others, and to my primary care physician, attion to my primary care provider I underst	provided above regarding other tttest the minor patient meets ulting, or arising from my receip ehalf of my child receiving the varty payor, including my employu ardian of the minor patient. 4) I ion, when they may occur, and or I have a history of an immediat the area without waiting, I ackr Emergency Use Authorization (" cine(s). 8) I have been offered at a dditional privacy protections or the authorizing physician, or the and that failure to check authon	immunizations for ligibility criteria for c or the minor's re accine, pregnant in er if they are payin will immediately a when and where I e allergic reaction owledge that I am (EUA") provided for ind/or provided a c under state or fedd e local Departmen ze/do not authoriz	r which I am due or el tr the vaccination. I als ceipt of this vaccination my third trimester, c g directly for my vacc ellert the pharmacist o should seek treatmer of any severity to a va doing so at my own or the vaccine(s) to be opy of the company's eral law, is subject to ! to f Health, if applicat we will serve as author	igible to receive or release Albe on Elease Albe on. I understa or I am unable ination; if the if any medical it. I am respon cine or inject isk and agains administered. Notice of Priviceporting by mole, and I autholization.) (Sout	re. The a rtsons C nd: 1) I I to return claim is conditio sible for able the t the ad I have I acy Prac by pharm orize the	bove information is companies and its su nave voluntarily cho n at a later date. 2) I denied, I understand ns which may adver following up with n rappy or if I have a hi vice of the profession and the opportunity tices in compliance nacy or its business a se disclosures. (New to, Maine, Massachu.	true and consisting as a sen to receive authorize. A fill will be reselved affect in a story of analystican story of analysis of ana	rect. I a ffiliates, e the value value the value the value the value the value the value value the value value the value v	attest I r, officer, officer, accinations Comple for onal hea xpense is due to ed the od all my urance unization orizenpshire
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