Herpes Zoster Consent Form:

Administering Pharmacists: Tom Henline, PharmD; Nicholas Gregg, PharmD; Ali Gregg, PharmD; Carl Cathell Jr., RPh

Gregg's Rx PHARMACY
Your Health is Our Business

Name (Last)	Name (First)	Date of Birth	Gender/Race
Address		**City**	**Zip**
Home Phone Number	**Cell Phone Number**	**Email Address**	
Emergency Contact Name	**Phone Number**	**Relationship to Patient**	
Primary Care Provider	**Primary Provider Location**	**Primary Provider Phone Number**	

PATIENT QUESTIONS- ANSWER ON THE DAY OF VACCINATION
Please mark yes or no for each question.

	Yes	No
1. Is the person to be vaccinated currently sick or experiencing a high fever?		
2. Has the person to be vaccinated ever received a vaccination of any type in the past?		
3. Has the person to be vaccinated had a serious reaction to a vaccine in the past?		
4. Does the person to be vaccinated have any allergies that produce a severe (anaphylactic) reaction?		
5. Does the person to be vaccinated have a known allergy or sensitivity to any component of the vaccine?		
6. Does the person to be vaccinated have any medical problems that make it hard to fight infection, such as cancer, leukemia, or HIV/AIDS?		
7. Does the person to be vaccinated have regular contact with someone with a weakened immune system?		
8. Is the person to be vaccinated taking cortisone, steroids, or anti-cancer drugs, or had x-ray cancer treatments?		
9. Has the person to be vaccinated received any other vaccinations within the past four weeks?		
10. Is the person to be vaccinated pregnant or planning to become pregnant within the next three months?		
11. Has the person to be vaccinated ever had tuberculosis?		
12. Is the person to be vaccinated 50 years or older?		
13. Is this the person to be vaccinated first or second dose? (please circle)	First	Second

I certify that I have received a copy of, read or had explained to me, and understand the CDC Vaccine Information Statement about the vaccination being administered.

All of the information that I have provided above is true and complete to the best of my knowledge, information, and belief. Any questions that I had that are relevant to my decision to grant or withhold consent to the vaccine have been answered to my satisfaction. I agree to stay in the general area for twenty (20) minutes after receiving my vaccination for medical observation. I authorized the release of any medical information or other information necessary to process an insurance claim if applicable. I also authorize a record of this immunization to be released to my physician and to the Maryland ImmuNet Immunization Registry. I understand and have fully considered the risks, possible side effects, and the potential benefits of the vaccine for the individual named below. My signature below indicates **that I am granting to Gregg's Pharmacy and its authorized staff my permission and informed consent to administer the appropriate vaccine to the person named below**. I understand that one or two doses may be necessary depending on the person's previous immunization history.

Patient Consent / Signature (or parent/guardian if patient is age 18 or under) **Date of Consent**

PHARMACY USE ONLY

Vaccine	Manufacturer	Route / Injection Site	Date
Expiration	**Lot Number**	**Name / Signature of Administrator**	
Billing Submitted		**Date Reported to MD Immunet**	

Pharmacist Name who reviewed this form:_____ **Signature:**_____