Matrx Pharmacy Vaccine Administration Record and Informed Consent

1030 Avenue D Suite 2, Snohomish, WA 98290

First Name: _____ Last Name: _____ Date of Birth: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Gender: _____ Medicare/Insurance: _____

Ethnicity: □Hispanic/Latino □Non-Hispanic or Latino □Decline to State Primary Care Physician Name: _____

Do you authorize this pharmacy to send your information to your Primary Care Physician? □**Yes** □**No**

Vaccine Requested: □Flu □COVID-19 □Pneumococcal □Tdap □RSV

1. Is the person to be vaccinated sick or injured today?	□**Yes** □**No**
2. Does the person to be vaccinated have allergies to medications, foods, vaccines, or latex? If yes, please list. _____	□**Yes** □**No**
3. Does the person to be vaccinated have a chronic health condition or long-term health problem? *Examples: heart, lung, kidney, neuromuscular, liver, metabolic diseases, asthma, diabetes, anemia, other blood disorders, neurologic or are they a smoker?*	□**Yes** □**No**
4. Has the person to be vaccinated ever had a reaction, fainted, or felt dizzy after receiving a vaccine?	□**Yes** □**No**
5. Has the person to be vaccinated ever had Guillain-Barre Syndrome?	□**Yes** □**No**
6. Is the person to be vaccinated currently pregnant, considering becoming pregnant in the next month, or breast-feeding?	□**Yes** □**No**
7. Does the person to be vaccinated have a weakened immune system?	□**Yes** □**No**
8. *(Tdap Only)* Has the person to be vaccinated ever had a seizure disorder, a brain disorder, or other nervous system problems?	□**Yes** □**No**
9. Have you had COVID in the last 3 months?	□**Yes** □**No**

I hereby give my consent to Matrx, as applicable, to administer the medication(s) I have requested above. I understand the benefits of receiving this medication and have received, read and/or had explained to me the Vaccine Information Statement and/or Vaccine Patient Fact Sheet for the vaccine(s) I have elected to receive. I acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering healthcare provider **Initials:_____**

I acknowledge that the administration of this vaccine may be reported to any required local, state, or federal health authorities. **Initials:_____**

I am aware a qualified pharmacy technician, or state authorized pharmacy intern, as allowed by law, might be administering this medication. **Initials:_____**

Patient/Legal Guardian/Recipient Name: _____ Signature: _____ Date: _____

The following section is to be completed by the healthcare provider ONLY. **Pharmacist Verification of DURs** □

Pharmacist Name (Print): _____ Pharmacist Signature: _____

Administering Individual Name and Title (Print): _____ Administration Date/Date VIS Given: _____

Vaccine	Lot #	Exp. Date	Manufacturer	Dosage	Site	Route	VIS Date	RPh Initials
					LA RA	SQ IM		
					LA RA	SQ IM		
					LA RA	SQ IM		