Twain Harte PHARMACY

Patient Registration/Consent Form

Place label here

Flu___(VIS 01/31/25) RSV___ (VIS 01/31/25)
Covid___(VIS 01/31/25) TDAP___(VIS 01/31/25)
Shingrix____(VIS 02/04/22) Pneumonia__(VIS 05/29/25)

Person receiving vaccine

First Name	MI	Last Name		
Address	City		State	Zip
Phone	Physician			
Date of Birth (MM/DD/YYYY)	Age	Gender		

Parent or Legal Guardian (if applicable)

First Name	Last Name
Relationship to Client	Phone

Screening Questions for person receiving vaccine (Please Circle)

1.	Are you feeling sick today? If yes, please do not attend the clinic.	YES	NO
2.	Have you ever had a flu vaccine?	YES	NO
3.	Have you ever had a serious reaction to any vaccine in the past?	YES	NO
4.	Do you have an allergy to a component of the vaccine? (MSG, gentamicin, gelatin)	YES	NO
5.	Have you ever been diagnosed with Guillain-Barre Syndrome?	YES	NO
6.	Are you pregnant or possibly pregnant?	YES	NO
7.	COVID ONLY: You certify that you are over 65 or have an underlying health condition.	YES	NO

Consent to Administer Vaccination & Enter Information Into Immunization Registry

To the best of my knowledge, I understand the benefits and/or risks of the vaccine I am receiving today. I hereby give consent to Twain Harte Pharmacy (THP) staff for the administration of the vaccine to myself or for the individual for whom I am authorized to make said request. I have received a copy of the most up-to-date Vaccine Information Statement (VIS). I understand that I will have the chance to ask questions and have them answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reaction from the vaccine. I fully release and hold harmless Twain Harte Pharmacy, its officers, directors, and employees from all liabilities or claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. THP is authorized to enter my vaccination information into the statewide immunization database. This information could be shared with my healthcare provider as part of my medical record.

I FULLY UNDERSTAND THAT I WILL BE ULTIMATELY RESPONSIBLE FOR ANY CHARGES if I am not a covered person under the insurance plan (program listed above), the services are not covered services, or any co-pays, deductibles or coinsurance obligations apply. Furthermore, I agree to remain near the vaccination location for approximately15-20 minutes after administration for observation by the administering healthcare provider.

Signature:	**Date:**
Relationship to Client:	