Froedtert & Medical College of Wisconsin

- ☐ Froedtert Pharmacy #025 — 9200 W. Wisconsin St. Milwaukee, WI 53226
- ☐ Froedtert Pharmacy #050 — 9200 W. Wisconsin St. Milwaukee, WI 53226
- ☐ Froedtert Pharmacy #075 — 9200 W Wisconsin St. Milwaukee, WI 53226
- ☐ Froedtert Pharmacy #100 — W180 N8085 Town Hall Rd. Menomonee Falls, WI 53051
- ☐ Froedtert Pharmacy #125 — W180 N8085 Town Hall Rd. Menomonee Falls, WI 53051
- ☐ Froedtert Pharmacy #150 — W180 N8000 Town Hall Rd Menomonee Falls, WI 53051
- ☐ Froedtert Pharmacy #175 — 1155 N. Mayfair Rd. Wauwatosa, WI 53226
- ☐ Froedtert Pharmacy #200 — 925 N. 87th St. Milwaukee, WI 53226
- ☐ Froedtert Pharmacy #225 — 9200 W. Wisconsin St. Milwaukee, WI 53226
- ☐ Froedtert Pharmacy #250 — 4805 S. Moorland Rd. New Berlin, WI 53151
- ☐ Froedtert Pharmacy #325 — 7901 S. 6th St. Oak Creek, WI 53124
- ☐ Froedtert Pharmacy #350 — 1700 W Paradise Drive West Bend, WI 53095

Vaccine Consent Form

Name:			Date of Birth/Age:
Address:			Allergies:
City:	State:	Zip:	Phone:

	Medical History (All Vaccines)	YES	NO	Don't Know
1	Are you sick today?			
2	Do you have allergies to latex, food, medications, or vaccine components? (Examples: eggs, thimerosal, gelatin, neomycin, phenol, or bovine protein)? If YES, please specify:			
3	Have you ever had a serious reaction after receiving a vaccine?			
4	Do you have any long-term health problem with heart disease, lung disease, asthma, kidney disease, diabetes, anemia or other blood disorder?			
5	Do you have an immunocompromising condition (i.e.: cancer, leukemia, lymphoma, HIV/AIDS, transplant, functional or anatomic asplenia, CSF leak or cochlear implant)?			
6	In the past 3 months have you taken medications that weaken your immune system (i.e.: cortisone, prednisone, or other steroids), or anti-cancer drugs, or have you had radiation treatments?			
7	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or any antiviral drug?			
8	Have you had a seizure or any brain or other nervous system problem (ie: Guillain Barre Syndrome)?			
9	Have you received any vaccinations in the past 4 weeks?			
10	For women: Are you pregnant or considering becoming pregnant in the next month?			
11	Have you received a Zoster or Shingrix vaccine?			

Vaccine	Manufacturer & Lot #	Expiration Date	Injection Site & Route	VIS Date	Date VIS given to pt
☐ Fluzone Quad			☐ L ☐ R Deltoid IM	8/15/2019	
☐ Fluzone High Dose			☐ L ☐ R Deltoid IM	8/15/2019	
☐ Fluarix Quad			☐ L ☐ R Deltoid IM	8/15/2019	
☐ Prevnar 13 (PCV13)			☐ L ☐ R Deltoid IM	10/30/2019	
☐ Pneumovax 23 (PPSV)			☐ L ☐ R Deltoid IM	10/30/2019	
☐ Boostrix (TDap)			☐ L ☐ R Deltoid IM	4/1/2020	
☐ Shingrix (Shingles)			☐ L ☐ R Deltoid IM	10/30/2019	
☐ Menveo (Men A)			☐ L ☐ R Deltoid IM	8/15/2019	
☐ Bexsero (Men B)			☐ L ☐ R Deltoid IM	8/15/2019	
☐ Havrix (Hep A)			☐ L ☐ R Deltoid IM	7/20/2016	
☐ Engerix-B (HepB)			☐ L ☐ R Deltoid IM	8/15/2019	
☐ Other:			IM/SQ		

Authorizing MD Name:	NPI:		Documentation:	☐ Dose 1	☐ Dose 2
Dr. Jonathan Truwit (CPA)	1518002450		☐ WIR	Date Dose 1 given:	
			☐ Scanned Consent Form		

I have received, read, and understand the Vaccine Information Statement provided by Froedtert and the Medical College of Wisconsin. I have had an opportunity to ask questions about the vaccine, and my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccination, the alternative modes or treatment, and I expressly consent, request and authorize the administration of the vaccination(s) documented above to me. I agree to stay in the general area for 15 minutes after receiving my vaccination to ensure that no immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. In the event my designated payor does not cover my immunization, I understand I may be financially responsible for the cost of the immunization. I hereby release the entity/organization that owns or leases the place in which I receive the vaccination, its officers, employees, and agents from any and all liability arising from the negligence of Froedtert and the Medical College of Wisconsin, its employees and agents, on behalf of myself, my spouse, my heirs and personal representatives. I hereby release Froedtert and the Medical College of Wisconsin, its officers, employees and agents, from any and all liability arising from this vaccination, except for liability arising from negligence, on behalf of myself, my spouse, my heirs and personal representatives.

Signature of person to receive vaccine OR their legal representative _____ Date/Time _____

Printed Name & Signature of Immunizing Pharmacist _____ NPI _____ Date/Time _____

Pharmacy Vaccine Consent Form - #60948

	COVID Screening Questions (All Vaccines)	YES	NO	Don't Know
1	In the last month have you been in contact with someone who was confirmed or expected to have the coronavirus/COVID-19?			
2	Do you have any of the following symptoms:			
	• Cough/cold/fever/shortness of breath or flu-like symptoms?			
	• Sore throat/loss of smell or taste?			
	• Abdominal pain/diarrhea?			
	• Abnormal bruising or bleeding/eye redness?			
3	Any international travel in the past month?			
4	FOR PHARMACY STAFF: Please review EPIC for COVID status and document below ☐ No COVID-19 test in EPIC ☐ Negative COVID-19 test in EPIC (Date: _____) ☐ Positive COVID-19 test in EPIC (Date: _____) ☐ Pending COVID-19 test in EPIC (Date: _____)			

***If the answer to any of these questions is YES, please alert vaccinating pharmacist for further evaluation.*

INSURANCE INFORMATION	
MEDICARE ID: *(Red/White/Blue Card, if available)*	
OTHER INSURANCE INFO: *(Medicare Part D/Advantage, Commercial insurance, etc.)*	Rx BIN:
	PCN:
	Rx ID:
	Rx Group:
	☐ Cardholder ☐ Spouse ☐ Child ☐ Other:

IMMUNIZATION ADMINISTRATION AND NEEDLE LENGTH GUIDE

Vaccine	Admin Route	Dose	Injection Site	Needle Size
Influenza HD	IM	0.5 mL	Deltoid muscle of arm	22-25 gauge
Influenza Quad	IM	0.5 mL	Deltoid muscle of arm	22-25 gauge
Hepatits A (Havrix)	IM	≤ 18 yrs: 0.5 mL	Deltoid muscle of arm	22-25 gauge
		≥ 19 yrs: 1 mL		
Hepatitis B (Engerix)	IM	≤ 19 yrs: 0.5 mL	Deltoid muscle of arm	22-25 gauge
		≥ 20 yrs: 1 mL		
HPV (Gardasil 9)	IM	0.5 mL	Deltoid muscle of arm	22-25 gauge
Varicella (Varivax)	SQ	0.5 mL	Fatty Tissue over triceps/ anterolateral thigh	23-25 gauge 5/8 "
IPV (Ipol)	IM	0.5 mL	Deltoid muscle of arm	22-25 gauge
Pneumococcal 13 (Prevnar 13)	IM	0.5 mL	Deltoid muscle of arm	22-25 gauge
Pneumococcal 23 (Pneumovax 23)	IM	0.5 mL	Deltoid muscle of arm	22-25 gauge
Meningococcal A (Menveo)	IM	0.5 mL	Deltoid muscle of arm	22-25 gauge
Meningococcal B (Bexsero)	IM	0.5 mL	Deltoid muscle of arm	22-25 gauge
Td (Tenivac)	IM	0.5 mL	Deltoid muscle of arm	22-25 gauge
Tdap (Boostrix)	IM	0.5 mL	Deltoid muscle of arm	22-25 gauge
MMR (MMR II)	SQ	0.5 mL	Fatty Tissue over triceps/ anterolateral thigh	23-25 gauge 5/8 "
Shingrix	IM	0.5 mL	Deltoid muscle of arm	22-25 gauge
MMRV (ProQuad)	SQ	0.5 mL	Deltoid muscle of arm	23-25 gauge 5/8 "
Rotavirus (RotaTeq)	Oral	2.0 ml	N/A	N/A

IMMUNIZATION ADMINISTRATION AND NEEDLE LENGTH GUIDE

	Weight (lbs)	Weight (kg)	Needle Length		Weight (lbs)	Weight (kg)	Needle Length
Women	<130	<60	5/8 to 1-inch	Men	<130	<60	5/8 to 1-inch
	130-152	60-70	1-inch		130-152	60-70	1-inch
	152-200	70-90	1 to 11/2 inch		152-260	70-118	1 to 11/2 inch
	>200	>90	11/2 inch		>260	>118	11/2 inch