VACCINATION CONSENT FORM 2025

****PLEASE WRITE LEGIBLY****

(LEGAL) FIRST Name: _____LAST Name:_____Sex:_____

Date of birth: _____/_____/_____ Age: _____ Telephone:_____

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

Last four of SSN#_____ Medicare ID (red/white/blue card)_____

1.	Are you sick today (fever, vomiting, diarrhea)?	□ Yes □ No □ I don't know
2.	Do you have any allergies to medication, food, vaccines, or latex?	□ Yes □ No □ I don't know
3.	Have you ever had a serious reaction after receiving a vaccination?	□ Yes □ No □ I don't know
4.	Do you have a long-term health problem like heart disease, lung disease, asthma, kidney disease, diabetes, anemia, blood disorder, nervous system problem, seizure disorder, or brain disorder?	□ Yes □ No □ I don't know
5.	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	□ Yes □ No □ I don't know

*****Signature***: _____ Date:_____**

EVERYTHING BELOW THIS LINE IS FOR PHARMACY USE ONLY:

Vaccine (Manufacturer)		Dosage	Site	NDC	Lot#	Expiration	VIS date
INFLUENZA (OTHER)							
□ Fluad Trivalent (HD)	IM	0.5mL	L / R	70461-0024-03			8/06/21
□ Afluria Trivalent (Vial)	IM	0.5mL	L / R	33332-0124-10			8/06/21
□ Afluria Trivalent (PFS)	IM	0.5 mL	L / R	33332-0024-03			8/06/21
COVID 2024-2025							
□ Spikevax/ Comrinaty	IM	0.5mL / 0.3mL	L / R				10/19/23
□ MNexSpike (HD C19)	IM	0.2	L / R				

Immunizer name:_____Immunizer signature:_____

Intern name (if applicable):_____Administration date:_____

Sigler Pharmacy:
Address: 4525 W 6th St, Lawrence, KS 66049
(P) 785-842-1225

Sigler Pharmacy Downtown:
Address: 1046 Vermont St, Lawrence, KS 66044
(P) 785-843-4160

Sigler Pharmacy Lenexa:
Address: 23351 Prairie Star Pkwy, Lenexa, KS 66227
(P) 913-768-6000