MUSC Consent Form / Vaccine Administration Record

This pharmacy is providing necessary vaccines to you in a safe and convenient setting in order to promote adherence to current immunization guidelines recommended by the CDC and ACIP. It does not take the place of an ongoing relationship with your primary care provider to address ongoing medical issues and other types of preventive care. We are providing your primary care provider with records of the vaccine(s) administered here so that your medical records may be complete, but be sure to take your personal record with you to your next appointment as well.

Vaccine: Flu COVID-19 Pneumococcal Shingles Tdap MMR HepA HepB Meningococcal Varicella Rabies HPV Typhoid Polio Other_____

First and Last Name:	Date of birth / /	Age	Gender
Address (Street, City, State)	Primary Care Doctor (Name, Phone # and Fax #)		
Phone #:	**Medication or Food Allergies**:		

Consent: ***Please review the statement below confirming your consent for vaccination and provide the information requested***

I have read, or had explained to me, the Vaccine Information Statement for the vaccine(s) I am receiving today.
I understand the risks and benefits, and have been provided an opportunity to ask questions, which have been answered to my satisfaction. I wish to receive the vaccine(s) and hereby give consent for the pharmacist to administer the vaccine(s) and communicate the administration of the vaccine(s) to my primary care practitioner, who is listed above.

MUSC email address (if applicable):

Signature of person receiving vaccine - OR - legal guardian **X**	Today's Date / / 2025

Screening Questions for ALL vaccines:	**Yes**	**No**
Are you sick today or do you have a fever?	○	○
Have you ever had a serious reaction to a vaccine, such as fainting or anaphylaxis?	○	○
Do you have any allergies to medications, foods, latex, or any vaccine component?	○	○
Do you have any long-term health problems with heart disease, kidney disease, liver disease, nervous system Disorders, respiratory disorders (COPD, asthma), blood disorders, or diabetes?	○	○
Do you have a weakened immune system because of HIV/AIDS or another disease affecting the immune system, Long-term treatment with high-dose steroids, or cancer treatments?	○	○
Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barre Syndrome or other nervous system problems?	○	○
Are you a parent, family member, or caregiver to a newborn infant?	○	○
For WOMEN only: Are you pregnant or considering becoming pregnant in the next month?	○	○
Screening questions in addition to the above questions, for LIVE Vaccines:		
Do you have any medical conditions that would affect your immune system, like cancer, leukemia, AIDS, or any other immune system problem?	○	○
Are you currently on home infusions or weekly injections of monoclonal antibodies, high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	○	○
Are you currently taking high-dose steroid therapy (>20mg/day of Prednisone) for more than 2 weeks?	○	○
Have you received any other vaccinations or skin tests in the past 28 days?	○	○
During the past year, have you received a blood transfusion, blood products, or been given a medication called immune globulin?	○	○

To be completed by the immunizing practitioner

RESET FORM

Medical University of South Carolina – MUSC Lancaster Outpatient Pharmacy

Signature of Vaccine Administrator _____ Pharmacist ☐ Intern ☐ Date VIS given: / / 2025

Vaccine Name/Dose #	Injection Site	Manufacturer	Lot Number	Expiration Date	VIS Date
	L ☐ R ☐				
	L ☐ R ☐				
	L ☐ R ☐				
	L ☐ R ☐				