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**Pediatric Vaccine Consent Form (FLU/COVID)**

Parent/Guardian: Answer the following questions to help us safely give your child vaccinations (Annual Influenza/COVID)

**Information for the child**

**Which vaccinations are you getting today?** Annual Influenza  / COVID Booster – 2023

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_ Parent/ Guardian Name: \_\_\_\_\_ Relationship – Parent or Guardian.

Mailing address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip code \_\_\_\_\_

Mobile Phone Number: \_\_\_\_\_ Home/ Alternative phone number: \_\_\_\_\_

Email: \_\_\_\_\_

Allergies: \_\_\_\_\_ Chronic conditions: \_\_\_\_\_

Do you have insurance? Yes/ No. IF yes, Name of the insurance provider: \_\_\_\_\_

Cardholder's name: \_\_\_\_\_ Date of birth \_\_\_\_\_ Relationship: \_\_\_\_\_

BIN Number: \_\_\_\_\_ PCN No: \_\_\_\_\_ ID No: \_\_\_\_\_ Rx-Group No: \_\_\_\_\_

**Race:** Circle one - *American Indian* or *Alaska Native* or *Asian Native* or *Hawaiian or Other Pacific Islander* *Black* or *African American* or *White* or *Other Race* or *Unknown* or *Decline to answer*

**Ethnicity:** Circle one – *Hispanic/ Latino* or *Non-Hispanic/non-Latino* or *Unknown ethnicity* or *Decline to answer*

Sex assigned at birth \_\_\_\_\_ Male/ Female.

Gender identity: Male/ Female/Transgender male/ Transgender female/ Genderqueer/non-binary/ Other/ Decline

Doctor/primary care provider name: \_\_\_\_\_ Phone: \_\_\_\_\_

All Vaccines	Yes	No	Don't Know
Is the child sick today?			
Does the child have allergies to medications, food (ie. eggs), latex or any vaccine component (i.e., neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast, or yeast)?			
Has the child had a serious reaction to a vaccine in the past?			
Does the child have a long-term health problem with lung, kidney, or metabolic disease (like diabetes), asthma, blood disorder, no spleen, complement component deficiency, a cochlear implant, or spinal fluid lead? <b>IF Yes – Please specify:</b>			
Does the child have cancer, leukemia, AIDS, or any other immune system problem?			
Does the child have a sibling or parent with an immune system problem?			
Do you have a neurological disorder such as seizures or other disorders that affect the brain or have had a disorder that resulted from a vaccine (i.e. Gullain-Barre Syndrome)?			
Does the child take cortisone, prednisone, other steroids, or anticancer drugs, or had X-ray treatments?			

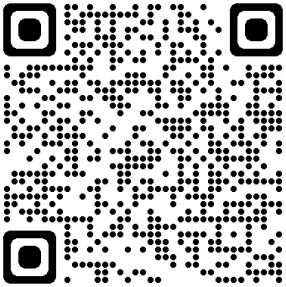
During the past year, have you received a transfusion of blood or blood products, including antibodies?			
Has the child received any vaccinations or skin tests in the past 4 weeks?			
<b>Did you bring your Immunization Record Card with you?</b>			

Parent or Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

**QR code for FLU VACCINE INFORMATION FACT SHEET.**

[Inactivated Influenza Vaccine Information Statement | CDC](#)

<https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.html>



**Post Vaccination Record/ For the Pharmacy Use only**

Name of the vaccination provided: \_\_\_\_\_

Site of administration: \_\_\_\_\_

Lot Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Vaccinator's Name/ Initials: \_\_\_\_\_

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