

# Informed Consent for Immunization with Inactivated Vaccine

M  F  Other

Last Name	First Name	Middle	Date of Birth	Age	Gender
				( ) -	

Home Address	City	State	Zip	Phone # <input type="checkbox"/> Home <input type="checkbox"/> Cell
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<b>Which arm do you prefer for vaccine?</b>	<b>Enter weight IF LESS than 66 pounds:</b>	<b>Lbs.</b>
(please circle)    Left    Right	<b>Primary Care Provider Name:</b> _____	<b>Vaccine requested:</b> _____
	<b>Primary Care Provider Address:</b> _____	

**Screening Questionnaire:** Please answer questions by checking the boxes.

Screening Questions – NOTE: IF COMPLETED ONLINE, REVIEW ANSWERS WITH PATIENT TO ENSURE NO CHANGES		Yes	No	
1.	Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	
2.	Do you have a serious allergy to ANY medications or food (e.g. eggs, gelatin, thimerosal, neomycin, gentamicin, etc.)? If yes, please list: _____	<input type="checkbox"/>	<input type="checkbox"/>	
3.	Have you ever had a serious reaction or fainted after receiving any vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Do you have sensitivity to latex (e.g. gloves or bandages)?	<input type="checkbox"/>	<input type="checkbox"/>	
5.	Do you have a seizure disorder or a brain disorder? (Tdap only)	<input type="checkbox"/>	<input type="checkbox"/>	
6.	For women: Are you pregnant or are you considering becoming pregnant in the next month?	<input type="checkbox"/>	<input type="checkbox"/>	
7.	Do you have a medical condition or take medication(s) that may weaken your immune system? If yes, please list: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Immunization Needs – NOTE: COVID-19 VACCINE CANNOT BE ADMINISTERED WITH OTHER IMMUNIZATIONS		Yes	No	Unsure
8.	Please check all that apply to you: <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Tobacco Smoker <input type="checkbox"/> 65 Years or older If you checked any of the above, have you ever received a PNEUMOCOCCAL vaccine? If yes, when? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	Patients 50 and older: Have you ever received the SHINGLES vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	How many years has it been since your last TETANUS vaccine?	_____ yrs		<input checked="" type="checkbox"/>
11.	Patients 45 and under: Have you received the HPV (Human Papillomavirus) vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12.	Patients aged 11 to 23: Have you received a meningitis vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
13.	Please indicate which vaccine(s) you would like more information about: <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> MMR (Measles, Mumps, Rubella) <input type="checkbox"/> Travel Vaccines <input type="checkbox"/> Other: _____			

**Informed Consent:** Please read and sign.

By my signature below, I consent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist or technician, where permitted by law or state/federal guidance, employed by Albertsons Companies or one of its affiliated pharmacies and to be contacted at the number provided above regarding other immunizations for which I am due or eligible to receive. I also release Albertsons Companies and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting or arising from my receipt of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination and understand that I am obligated to pay for all products and services received, if applicable. 2) I may be responsible for payment after the date of service if the product or service is billed to my medical benefit. 3) I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient. 4) I will immediately alert the pharmacist of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine. 5) I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects. 6) I should remain in the area for 15 minutes after the vaccination for observation. 7) I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization ("EUA") provided for the vaccine(s) to be administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). 8) I have been offered and/or provided a copy of the company's Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA). 9) This vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting by my pharmacy or its business associate to an immunization registry, which may share my immunization data with others, and to my primary care physician, the authorizing physician, or the local Department of Health, if applicable, and I authorize these disclosures.

**X**

\_\_\_\_\_  
**Signature of Patient or Parent/Guardian of Minor Patient** Date

**For Pharmacy Use Only**

Vaccine Name	Lot #	Expiration Date	Manufacturer	Dose (ml)	Dose #	Route	Site (circle)	VIS/EUA Publication Date
COVID 19	EW0161	07-20-2021	PFIZER	0.5ml		IM	R / L Deltoid	12-20
							R / L Deltoid	
							R / L _____	
							R / L _____	

Signature of RPh: *Miri Bassan RPh* Title of Administrator: \_\_\_\_\_ Administration Date: 05-13-21 NPP Offered:  RPh

Signature indicates (1) VIS/EUA Provided and (2) Counseling offered (Please circle) **Accepted Declined**  
**Billing Info (off-site only):**  Medicare (ID# including letters) or Medical (Name, ID#, Group#, Payer ID) if UHC \_\_\_\_\_

Last 4 digits of SSN: \_\_\_\_\_

BIN: \_\_\_\_\_ PCN: \_\_\_\_\_ Group#: \_\_\_\_\_ ID#: \_\_\_\_\_

Question	Y	N
Have you received a dose of COVID-19 vaccine? If yes which product and when? Manufacturer: _____ Date: _____		
Have you ever had an allergic reaction after receiving a COVID-19 vaccine?		
Have you received any other vaccinations in the past 14 days?		
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 within the last 90 days?		
Have you ever had a serious reaction to polyethylene glycol (PEG) or polysorbate?		

Question	Y	N
Have you ever had a severe allergic reaction to any vaccine, injectable therapies, food, pet, venom, environmental allergies, or oral medications for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital? If yes, please list:		
Do you have a bleeding disorder or do you take a blood thinner?		
Last 4 of SSN:		
(For Uninsured Patients) DL#:		
To the best of my ability, I have verified this patient meets current eligibility requirements. Staff Initials: <u>UB</u>		