my PHARMACY & OPTICAL

FACILITY NAME: _____

Consent for Inactivated Vaccine Administration

PATIENT INFORMATION

Name (as it appears on insurance card): _____ Date of Birth: _____ Age: _____

☐ Male ☐ Female Phone: _____ SSN: _____ Medicare ID: _____

Street Address: _____ Room/Unit #: _____ City: _____ State: _____ Zip _____

Primary Care Provider (PCP):_____ PCP Phone:_____

Initials	**High Dose Flu (age 65y+)**	*Initials*	**Regular Flu (age 6m-64y)**	*Initials*	**Shingles**	*Initials*	**RSV**	*Initials*	**Tdap**	*Initials*	**Pneumonia**	*Initials*	**COVID**

Please initial box to the left of requested vaccine(s)

Screening Questions	**YES**	**NO**	**UNSURE**
1. Are you sick today? If yes, (1) Do you have a new fever? Y/N (2) Do you have a cough? Y/N (3) Do you have diarrhea? Y/N (4) Have you been vomiting? Y/N	____	____	_____
2. Have you ever fainted or felt dizzy after receiving a vaccine?	____	____	_____
3. Have you ever had a reaction after receiving a vaccine?	____	____	_____
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?	____	____	_____
5. Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	____	____	_____
6. Do you have allergies to latex, medications, food, or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal) If yes, please list: _____	____	____	_____
7. Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barré syndrome or other nervous system problems?	____	____	_____
8. For women: Are you pregnant or considering becoming pregnant in the next month?	____	____	_____

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 will be providing the designated physician or primary care provider (as listed below) 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. 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 appropriate vaccine(s). I understand the risks and benefits and have had sufficient time to thoughtfully consider whether to accept or decline this vaccine. I have been provided an opportunity to ask questions, which have been answered to my satisfaction. I wish to receive the appropriate vaccine(s), and I am in no way being unduly influenced, coerced, or otherwise forced to receive this vaccine, and hereby give consent for My Pharmacy to administer the vaccine(s)." I further understand that the requested vaccine may not be approved by the FDA and may be an investigational medical product and/or is being made available through an Emergency Use Authorization (EUA). EUA means the vaccine is being made available without FDA approval due to a public health emergency. I understand that because the provided vaccine may be investigational in nature and/or may be available through an EUA, this means that it may not have undergone rigorous scientific evaluation by the FDA. I acknowledge that the manufacturer of the vaccine, the FDA, my doctor, the individual administering the vaccine, and any other covered person assisting in providing me access to this vaccine CANNOT be taken to court for money damages related to me receiving this vaccine, including for any injuries, or any other type of loss, such as (i) death; (ii) physical, mental, or emotional injury, illness, disability, or condition; (iii) fear of such injury, including medical monitoring costs; or (iv) loss of or damage to property, including business interruption loss.

_____ _____ _____

Patient/Guardian Printed Name **Signature of Patient/Guardian (or name of who received the verbal consent)** **Date of Consent**

Pharmacy Use Only

Vaccine & Manufacturer		**Vaccine & Manufacturer**		**Vaccine & Manufacturer**		**Vaccine & Manufacturer**	
Lot #	**Exp Date**	**Lot #**	**Exp Date**	**Lot #**	**Exp Date**	**Lot #**	**Exp Date**
Volume **mL**	**Route** **IM**	**Volume** **mL**	**Route** **IM**	**Volume** **mL**	**Route** **IM**	**Volume** **mL**	**Route** **IM**
Admin Site	**Admin Date/Date Vis Given**	**Admin Site**	**Admin Date/Date Vis Given**	**Admin Site**	**Admin Date/Date Vis Given**	**Admin Site**	**Admin Date/Date Vis Given**

RX Insurance Information:

Insurance Name: _____

RX BIN: _____

RX PCN: _____

Cardholder ID: _____

RX Group: _____

VIS Dates: Flu 8/6/21; Pneumonia 5/12/23; RSV 10/17/24; Tdap 8/6/21; Shingles 2/4/22; COVID 10/17/24

IMMUNIZER NAME: _____ **IMMUNIZER SIGNATURE:** _____ **Date:** _____