INFORMED CONSENT TO RECEIVE VACCINES

First Name _____ *MI* _____ *Last Name* _____

Home Phone _____ *Date of Birth (mm/dd/yyyy)* _____ *Age* _____ *Gender* *M F* *Pregnant?* *Y N*

Home Address _____ *City* _____ *State* _____ *Zip Code* _____

____American Indian or Alaskan; ___Native Hawaiian or Pacific Islander; ___Asian; ___Black/African American; ___White/Caucasian; ___Hispanic/Latino; ___Other

Please answer the following questions:	Yes	No	Unsure
1. Do you have a fever or illness today?	___	___	___
2. Have you experienced in the past 14 days: fever, unusual cough, or unusual shortness of breath?	___	___	___
3. Have you or a household contact been diagnosed with COVID-19 in the past 14 days?	___	___	___
4. Have you received any vaccinations in the last 14 days? If so, list here: _____	___	___	___
5. Do you have allergies ANY to medications, food (e.g. eggs), latex, or a vaccine component (e.g. bovine protein, gentamicin, polymyxin, neomycin, phenol, PEG (polyethylene glycol), or thimerosal)?	___	___	___
6. Have you ever had a serious reaction to a vaccine in the past?	___	___	___
7. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem?	___	___	___
8. Do you have a chronic condition or long-term health problem**? If yes, please check all that apply.** ___Anemia ___Asthma ___Diabetes ___ Heart___ Kidney___ Liver___ or Lung disease ___Other	___	___	___
9. For the past 3 months, have you taken medications that affect your immune system: steroids, anti-cancer drugs, drugs for rheumatoid arthritis, Crohn's disease, psoriasis, or had radiation treatments?	___	___	___
10. Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder?	___	___	___

I have received a Notice of Privacy Practice for HIPAA. I have read, or have had read to me, the Vaccine Information and had the opportunity to ask questions about the vaccine(s), and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to the administration of the vaccine(s) requested. I authorize the information to be forwarded to my primary care physician, State Immunization Registry, or the local Dept. of Health, if applicable. **I agree to stay in the general area for 15 minutes** after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); the subsidiaries and affiliates of the pharmacy; the respective directors, officers, employees, and agents of the pharmacy and its subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability that might arise from this vaccination. I agree that I am responsible for insurance co-pays or the cost of administered vaccines not covered by insurance.

Patient Signature: _____ Date
(Parent or Guardian, if minor)

Vaccine Information (Office use only)

Vaccine 1 _____ Lot # _____ Exp. Date _____ Manufacturer _____ Dose (ml) _____ VIS Date _____

IM or SubQ Route _____ *Left Arm or Right Arm* Admin. Site _____ Admin. Date _____ Administered by _____ Title _____

Vaccine 2 _____ Lot # _____ Exp. Date _____ Manufacturer _____ Dose (ml) _____ VIS Date _____

IM or SubQ Route _____ *Left Arm or Right Arm* Admin. Site _____ Admin. Date _____ Administered by _____ Title _____

Prescriber Signature _____ Store Info _____ Prescription Date _____