IMMUNIZATION INFORMED CONSENT

First Name | *MI* | *Last Name*

Cell Phone | *Date of Birth (mm/dd/yyyy)* | *Age* | *M F Gender*

Home Address | *City* | *State* | *Zip Code*

Email Address | *SS# - OR - Driver's License State and #*

___ American Indian or Alaska Native; ___ Native Hawaiian or Pacific Islander; ___Asian; ___ Black/African American; ___ White; ___Hispanic/Latino; ___Other

	The following questions will help us determine your eligibility to be vaccinated today.	Yes	No	???
	1. Do you have a fever or illness today?	___	___	___
	2. Have you experienced any of the following in the past 14 days: fever, unusual cough, unusual shortness of breath?	___	___	___
	3. Have you or a household contact been diagnosed with COVID-19 in the past 14 days?	___	___	___
	4. Do you have allergies to medications, food (e.g. eggs), latex, or a vaccine component (e.g. bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol or thimerosal)?. If yes, please list the allergies _____	___	___	___
	5. Have you been diagnosed with heart inflammation (myocarditis or pericarditis) in the past?	___	___	___
	6. Have you ever had a serious reaction to any 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. Are you 65 years of age or older?	___	___	___
	9. Do you have a chronic condition or long-term health problem**? If yes, please check all that apply.** ___Anemia ___Asthma ___Diabetes ___Heart disease ___Kidney disease ___Liver disease ___Lung disease ___Obesity ___Smoker	___	___	___
	10. If you answered YES to question 9 or 10, have you ever had a pneumonia vaccination?	___	___	___
	11. Have you ever had a shingles vaccination (for patients 50 years of age and older only)?	___	___	___
	12. **For women**: Are you pregnant or considering becoming pregnant in the next month?	___	___	___
LIVE VACCINES	13. For the past 3 months, have you taken medications that affect your immune system, such as predisone or other steroids, anti-cancer drugs, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis; or have you had radiation treatments?	___	___	___
	14. Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or are you in contact with anyone who has a severely weakened immune system?	___	___	___
	15. Have you received a transfusion of blood or blood products, or been given immune (gamma) globulin in the past year?	___	___	___
	16. Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)	___	___	___
	17. If the patient receiving vaccine is under 5 years old, is there a history of asthma or wheezing? (for FluMist® only)	___	___	___
	18. Does the patient have a nasal condition serious enough to make breathing difficult, such as a very stuffy nose? (for FluMist® only)	___	___	___

I certify I am the patient and at least 18 years of age; the legal guardian of the patient; or a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. I have received a Notice of Privacy Practice for HIPAA. I have read, or have had read to me, the Vaccine Information Statement (VIS) or EUA referred to above. I have been able 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 physician, the authorizing physician, State Immunization Information System, or the local Dept. of Health, if applicable. **I agree to stay in the general area for 15-30 minutes** after receiving my vaccination in case any immediate reactions occur. 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

Patient Signature: _____ Date: _____

(Parent or Guardian, if minor)

Vaccines Provided Today:

☐ Influenza Quadrivalent ☐ Influenza Adjuvanted (65+) ☐ Influenza (65+) ☐ Influenza Recombinant (FluBlok) ☐ COVID-19 Vaccine
☐ Influenza Cell-Based (Flucelvax) ☐ LAIV (FluMist) ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis A/B (Twinrix) ☐ HPV-9
☐ Pneumococcal PSV23 ☐ Pneumococcal PCV13 ☐ Men ACWY ☐ Men B ☐ Shingles ☐ Tdap ☐ Other:_____

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Apply vaccine label here vaccine, lot, exp date, manufacturer, dose (ml)	Route	Right or Left Arm Admin. Site	Admin. Date	VIS Date (on form)	Administrator*
Apply vaccine label here vaccine, lot, exp date, manufacturer, dose (ml)	Route	Right or Left Arm Admin. Site	Admin. Date	VIS Date (on form)	Administrator*

By signing as administrator you are confirming that contraindications and side effects have been reviewed and a current VIS was provided to the patient receiving the vaccine