Informed Consent for Immunization with Inactivated & Live Vaccines

❒ M ❒ F ❒ Other

Last Name | **First Name** | **Middle** | **Date of Birth** | **Age** | **Gender**

Home Address | **City** | **State** | **Zip** | **Phone #** ( ) - ❒ Home ❒ Cell

Vaccine(s) requested: ❒ Flu ❒ COVID-19 ❒ Pneumonia ❒ Shingles ❒ Tetanus ❒ Other(s): _____

Which arm do you prefer for vaccine? ❒ Left ❒ Right

Ethnicity: ❒ Hispanic or Latino ❒ Non-Hispanic or Latino ❒ Decline to State (Unknown)

If less than 66 pounds list weight: ____Lbs.

Race: ❒ Asian ❒ American Indian ❒ Pacific Islander ❒ Black or African American ❒ Caucasian ❒ Two or More ❒ Other

Medicare Part B ID#: _____

Last 4 digits of SSN (Medicare patients only): _____

Email address: _____

Primary Care Provider

Name: _____

Phone: _____ Address: _____

Screening Questions – IF COMPLETED ONLINE, REVIEW ANSWERS WITH PATIENT TO ENSURE NO CHANGES		Yes	No
1.	Are you sick today?	❒	❒
2.	Do you have any allergies to medications, food or vaccines? If yes, please list:_____	❒	❒
3.	Have you ever had a serious reaction or fainted after receiving a vaccination?	❒	❒
4.	Do you have a medical condition or take medication(s) that may weaken your immune system? (e.g. cancer, leukemia, HIV, active shingles, take prednisone, oral steroids, anticancer or antiviral drugs)	❒	❒
5.	Have you ever received a dose of COVID -19 vaccine? *(COVID-19 only)* If yes, which product did you receive? ❒ Pfizer ❒ Moderna ❒ J&J Date(s): _____	❒	❒
6.	For women: Are you pregnant or are you considering becoming pregnant in the next month?	❒	❒
7.	Do you have a seizure disorder or a brain disorder? *(Tdap only)*	❒	❒

Immunization Needs		Yes	No	Unsure
8.	Please check all that apply to you: ❒ Asthma or lung disease ❒ Diabetes ❒ Heart Disease ❒ Tobacco Smoker ❒ 65 Years or older. If you checked any of the above, have you ever received a PNEUMONIA vaccine? If yes, when and what kind(s)? _____	❒	❒	❒
9.	Patients 50 and older or immunocompromised: Have you ever received the SHINGLES vaccine? If so, what date(s): _____	❒	❒	❒
10.	How many years has it been since your last TETANUS vaccine?	_____ yrs		❒
11.	Patients 19 to 59 years old: Have you received a hepatitis B series?	❒	❒	❒
12.	Patients under 46: Have you received the HPV (Human Papillomavirus) vaccine?	❒	❒	❒
13.	Patients aged 11 to 23: Have you received a meningitis vaccine?	❒	❒	❒
14.	Please indicate which vaccine(s) you would like more information about? ❒ Hepatitis A ❒ MMR (Measles, Mumps, Rubella) ❒ Travel Vaccines ❒ Childhood Vaccines ❒ Other:_____ ❒ Unsure: would like an assessment done of potential vaccination gaps or needs			

Live Vaccines Only (chickenpox, cholera, intranasal flu, MMR® II, rotavirus, oral typhoid, and yellow fever)		Yes	No
15.	Have you received any vaccination in the past 4 weeks? If yes, please list: _____	❒	❒
16.	During the past year, have you received a transfusion of blood or blood products, been given a medicine called immune (gamma) globulin, or had radiation therapy?	❒	❒
17.	Have you had your thymus gland removed or a history of problems with your thymus such as myasthenia gravis, DiGeorge syndrome, or thymoma? *(yellow fever only)*	❒	❒
18.	Are you currently taking any antibiotics or antimalarial medications? *(oral typhoid only)*	❒	❒
19.	Do you have a history of thrombocytopenia or thrombocytopenia purpura? *(MMR® II only)*	❒	❒
20.	For age under 18: Are you taking aspirin or an aspirin containing medication? *(intranasal flu only)*	❒	❒

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, or other authorized person, where permitted by law or state/federal guidance, employed or contracted 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. The above information is true and correct. I attest I meet eligibility criteria for the vaccination (if any); if I am the parent/guardian of the minor patient, I attest the minor patient meets eligibility criteria for the vaccination. 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 or the minor's receipt of this vaccination. I understand: 1) I have voluntarily chosen to receive the vaccination. 2) *Non-COVID vaccine:* I authorize Albertsons Companies to submit a claim for reimbursement on my behalf to Medicare or any other contracted third-party payor; if the claim is denied, I understand I will be responsible for payment; 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 observation for 15 minutes unless I have a history of an immediate allergic reaction of any severity to a vaccine or injectable therapy or if I have a history of anaphylaxis due to any cause, I should remain in the area for observation for 30 minutes after the vaccination. If I leave the area without waiting, I acknowledge that I am doing so at my own risk and against the advice of the professional who administered the vaccine. 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. (*New Jersey Only: I authorize ___ do not authorize ___ reporting of my receipt of this vaccination to my primary care provider I understand that failure to check authorize/do not authorize will serve as authorization.*) *(South Dakota, Maine, Massachusetts, and New Hampshire only: I understand I have the right to object to the sharing of my data to the above-mentioned parties through such registries.)*

X _____

Signature of Patient or Parent/Guardian of Minor Patient **Printed Name** **Date**

For Pharmacy Use Only

Vaccine Name	Lot #	Expiration Date	Manufacturer	Dose (ml)	Dose #	Route	Site (circle)	VIS/EUA Pub. Date
COVID-19(_____)					#____	*IM*	*R / L Deltoid*	
Flu (_____)						*IM*	*R / L Deltoid*	
Shingrix®			***GSK***	*0.5*	❒ 1 ❒ 2	*IM*	*R / L Deltoid*	***2/4/2022***
Prevnar 20®			***Pfizer***	*0.5*	*1*	*IM*	*R / L Deltoid*	***2/4/2022***
							R / L _____	
							R / L _____	

Ordering RPh Signature:_____

Name of Administrator:_____

Administration Date: _____ ❒ **NPP Offered**

Counseling (Please circle): Accepted / Declined

RxBIN: _____ **PCN**:_____ **Group #**:_____ **ID#**: _____

Medical (Name, ID#, Group#, Payer ID - if UHC): _____

Billing Info (off-site only)

Clinic Name: _____ **Clinic Address**: _____

***WA ONLY*: Substitution Permitted**:_____ **Dispense as Written**: _____