Informed Consent for Immunization with Inactivated Vaccine

Last Name	First Name	Middle	Date of Birth	Age	❒M ❒F ❒Other Gender

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

Which arm do you prefer for vaccine?	Enter weight IF LESS than 66 pounds: Lbs.
(please circle) Left Right	Primary Care Provider Name: _____ Vaccine Requested: _____

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

	Screening Questions	Yes	No	
1.	Are you sick today?	❒	❒	
2.	Do you have a serious allergy to ANY medications or food (e.g. eggs, gelatin, thimerosal, neomycin, gentamicin, etc.)? If yes, please list: _____	❒	❒	
3.	Have you ever had a serious reaction or fainted after receiving any vaccination?	❒	❒	
4.	Do you have sensitivity to latex (e.g. gloves or bandages)?	❒	❒	
5.	Do you have a seizure disorder or a brain disorder? *(Tdap only)*	❒	❒	
6.	For women: Are you pregnant or are you considering becoming pregnant in the next month?	❒	❒	
7.	Do you have a medical condition or take medication(s) that may weaken your immune system? If yes, please list: _____	❒	❒	

	Immunization Needs	Yes	No	Unsure
8.	Please check all that apply to you: ❒ Asthma ❒ Diabetes ❒ Heart Disease ❒ Tobacco Smoker ❒ 65 Years or older If you checked any of the above, have you ever received a PNEUMOCOCCAL vaccine? If yes, when? _____	❒	❒	❒
9.	Patients 50 and older: Have you ever received the SHINGLES vaccine?	❒	❒	❒
10.	How many years has it been since your last TETANUS vaccine?	_____ yrs		❒
11.	Patients 45 and under: Have you received the HPV (Human Papillomavirus) vaccine?	❒	❒	❒
12.	Patients aged 11 to 23: Have you received a meningitis vaccine?	❒	❒	❒
13.	Please indicate which vaccine(s) you would like more information about? ❒ Hepatitis A ❒ Hepatitis B ❒ MMR (Measles, Mumps, Rubella) ❒ Travel Vaccines ❒ 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, 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. 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 not of legal age and have obtained the signed consent of a parent or guardian. 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 have been advised that 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") 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. 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 **Date**

For Pharmacy Use Only

Vaccine Name	Lot #	Expiration Date	Manufacturer	Dose (ml)	Route	Site (circle)	VIS Publication Date
Flu (_____)				*0.5 / 0.7*	*IM*	*R / L Deltoid*	*8-15-19*
Shingrix			GSK	*0.5*	*IM*	*R / L Deltoid*	*10-30-19*
						R / L _____	
						R / L _____	

Signature of RPh: _____ **Initials of Administrator:** _____ **VIS Given and Administration Date:** _____

Off-Site Clinics ONLY: Name and Address of Location _____

Medicare (ID# including letters) or Medical (Name, ID#, Group#, Payer ID if UHC) _____

Prescription (BIN, PCN, Group#, ID#, Person Code) _____

COVID-19 Screening Questionnaire for Immunizations, Medication Administration or Hormonal Contraception Services

Assessment Criteria	Yes	No
1) Do you have a fever?	❒	❒
2) Do you have a cough and/or shortness of breath?	❒	❒
3) In the past 14 days have you had close contact with a lab-confirmed COVID-19 patient?	❒	❒