Informed Consent for Immunization with Inactivated Vaccine

❒ M ❒ F ❒ Other

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

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

Medicare Part B ID#: _____ **Last 4 digits of SSN:** _____ **Driver's License #:** _____

Race: ❒ Asian ❒ Black or African American ❒ Hispanic ❒ American Indian ❒ Caucasian ❒ Pacific Islander ❒ Two or More ❒ Other: _____
Ethnicity: ❒ Hispanic or Latino ❒ Non-Hispanic or Latino ❒ Decline to State (Unknown)

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

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

Screening Questions – NOTE: IF COMPLETED ONLINE, REVIEW ANSWERS WITH PATIENT TO ENSURE NO CHANGES		**Yes**	**No**	
1.	Are you sick today?	❒	❒	
2.	Do you have a serious allergy to ANY medications, food, pet, environmental allergens, oral medication or latex? (e.g. eggs, gelatin, thimerosal, neomycin, gentamicin, polyethylene glycol (PEG), polysorbate etc.)? If yes, please list: _____	❒	❒	
3.	Have you ever had a serious reaction or fainted after receiving any vaccination or injectable medication?	❒	❒	
4.	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: _____	❒	❒	
5.	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19 within the last 90 days? *(COVID-19 only)*	❒	❒	
6.	Do you have a seizure disorder or a brain disorder? *(Tdap only)*	❒	❒	
7.	Do you have a medical condition or take medication(s) that may weaken your immune system? If yes, please list: _____	❒	❒	
8.	For women: Are you pregnant or are you considering becoming pregnant in the next month?	❒	❒	
Immunization Needs		**Yes**	**No**	**Unsure**
9.	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 PNEUMONIA vaccine? If yes, when? _____	❒	❒	❒
10.	Patients 50 and older: Have you ever received the SHINGLES vaccine?	❒	❒	❒
11.	How many years has it been since your last TETANUS vaccine?	_____ yrs		❒
12.	Patients 45 and under: 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 ❒ 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, 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 that: 1) I have voluntarily chosen to receive the vaccination and understand that I am obligated to pay for all products and services received, if applicable. 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 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 and Massachusetts 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 **Date**

For Pharmacy Use Only

Vaccine Name	**Lot #**	**Expiration Date**	**Manufacturer**	**Dose (ml)**	**Dose #**	**Route**	**Site** (circle)	**VIS/EUA Publication Date**
							R / L Deltoid	
							R / L Deltoid	
							R / L Deltoid	

Name of Administrator: _____ **Administration Date**: _____ ❒ **NPP Offered** **RPh Counseling (Please circle):** Accepted / Declined
RPh Signature [Indicates (1) VIS/EUA Provided (2) Counseling Offered and (3) Patient Eligibility Verified]: _____
***WA ONLY*: Substitution Permitted**: _____ **Dispense as Written**: _____
RxBIN: _____ **PCN**: _____ **Group #**: _____ **ID#**: _____
Medical (Name, ID#, Group#, Payer ID - if UHC): _____
Billing Info (off-site only) Clinic Name: _____ **Clinic Address**: _____

COVID-19 Screening Questionnaire for Immunizations, Ambulatory Services, Appointment Based Services

Assessment Criteria
1) Do you have any of the following symptoms that are unusual for you? • Cough? • Shortness of breath? • Sore throat? • Chills? • Congestion or runny nose?
2) Do you have diarrhea or nausea/vomiting?
3) Do you have a fever?