

PATIENT INFORMATION & CONSENT

Check the box by each vaccine requested. We accept Aetna, BCBS, Cigna, Humana, United Health PPO's and Medicare B (flu only).

- Influenza Shot:** I am not allergic to eggs or egg products or thimerosal, do not have acute febrile illnesses (Fever>101° F) and have not had an anaphylactic reaction or developed Guillain-Barré syndrome after receiving a previous influenza vaccination. **VIS given: annual**
- COVID-19:** I have not experienced anaphylaxis (difficulty breathing) or severe allergic reactions from a previous COVID-19 vaccine and I do not have a bleeding disorder or use a blood thinner. I am not allergic to any ingredients in the COVID-19 vaccine, including mRNA. **VIS given: 1/31/25**
- HPV (Gardasil 9):** I have not had a reaction to any vaccine, am not pregnant, do not have acute febrile illness or a weakened immune system. **VIS given: 8/6/21**
- Hepatitis A:** I am not allergic to aluminum hydroxide, sodium borate and /or sodium chloride. **VIS given: 1/31/25**
- Hepatitis B:** I do not have multiple sclerosis and am not hypersensitive to yeast, formaldehyde, aluminum hydroxide or thimerosal. **VIS given: 1/31/25**
- Meningococcal (Menquadfi)** I had no prior reaction to a tetanus toxoid-containing vaccine and am not pregnant. **VIS given: 1/31/25**
- Measles Mumps Rubella (MMR):** I have not had a reaction to a prior dose or any vaccine components, am not pregnant, do not have acute febrile illness or a weakened immune system. I have not had another live vaccine in last 4 weeks. **VIS given: 1/31/25**
- Pneumonia:** I am over 50 and not pregnant or have a chronic health condition or am a child at risk. I have not had a dose of PPSV in the last 12 mos. I am not allergic to Diphtheria. **VIS given: 5/29/25**
- RSV (Arexvy/Abryso):** I am over 50, do not have a fever or severe illness and have not had a prior allergic reaction to vaccines. **VIS given: 1/31/25**
- Tetanus, Diphtheria and Pertussis (TDAP):** I am not allergic to aluminum phosphate, formaldehyde, glutaraldehyde, 2-phenoxyethanol or a prior DTaP Vaccine and have not had encephalopathy, or progressive neurological disorder. **VIS given: TDAP 1/31/25**
- Shingles (Shingrix):** I am at least 50 years old, not pregnant or breastfeeding, have not had a Zostavax vaccine within 8 weeks or a severe allergic reaction to any component of the vaccine (anaphylaxis) or after a previous dose of Shingrix. **VIS given: 2/4/22**

Patient Information Section-attach photocopy of insurance (front only) and driver's license

We don't accept HMO plans other than BCBS TRS. We do not accept- BCBS prefixes: VEL, ZGN, ZGZ & ZSA ZGP Groups: 000689,000748, 000940, 000955, 000956, 000301, 00700, 090047, 023530, 023535, 023540, 045636, 045637, 219319, Aetna Assurant SRC, Aetna Exxon, Cigna Local Plus, US Health, United Navigate, Medicare Railroad or Any Bronze, Silver, Gold, Marketplace Plans.

Yes/ No Are you sick today or have you had a fever in the past 48 hours? _____ / _____
 Yes/ No Are you pregnant or nursing? _____
 Yes/ No Do you have any allergies? List all medicine or vaccine allergies _____
 Yes/ No I am giving permission to the vaccinator to provide a copy of my vaccine record (consent) to my employer if requested. _____

_____ / _____ / _____
Patient Last Name First Name Middle I Birth Date M/D/Y Age Sex
 _____ / _____ / _____
 If same person, skip this line **Primary Insured Last Name** First Name Middle I Birth Date M/D/Y Sex

_____ - _____
Patient Address: Street City State County Zip Daytime Phone Number

_____ / _____ - _____
 Signature of person receiving vaccine or Guardian Emergency Contact Person/ Emergency Phone #

E-mail: _____

If you have any questions, please ask now or check with your physician before receiving the vaccine. I understand the benefits and risks of these vaccinations and request those indicated above to be given to me. If you experience any significant reactions, see your physician. Please note that by signing this form you are accepting responsibility for all costs not covered by your insurance.

For Clinic Use Only below this point:

Vaccine Administered (nurse checks box by vaccine given)	Lot #	Exp Date	Amount/Site	Injection Site
Influenza Sanofi Fluzone ≥6mos <input type="checkbox"/> MDV <input type="checkbox"/> Thim Free <input type="checkbox"/> High Dose=>65yr Seqirus Flucelvax ≥6mos <input type="checkbox"/> MDV <input type="checkbox"/> Thim Free Seqirus Afluria ≥6 mos <input type="checkbox"/> MDV <input type="checkbox"/> Thim Free Seqirus <input type="checkbox"/> Fluad ≥65yr GSK <input type="checkbox"/> Fluarix <input type="checkbox"/> Flulaval ≥6mos		6/30/2026	0.25ml ≤ 3yr IM Afluria 0.5 ml >6 mos IM for Flucelvax and Fluarix/Fluzone/ High Dose,Fluad	Left Right
COVID-19 <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer HPV <input type="checkbox"/> Gardasil (Merck) (9-14 or 15-45yrs) 0, 6 to 12 mos or 0, 2, 6 mos Hepatitis A <input type="checkbox"/> Havrix (GSK) <input type="checkbox"/> Vaqta (Merck) ≥1yr 0, 6 months Hepatitis B <input type="checkbox"/> Energix (GSK) <input type="checkbox"/> Recombivax (Merck) 0, 1, 6 mos			0.5 ml >12yr IM 0.5 ml >18yr IM 0.5 ml ≤18yr IM 1.0 ml >19yr IM 0.5 ml <19yr IM	Left Right
Meningococcal <input type="checkbox"/> Menquadfi (6mo+)			0.5 ml IM	Left Right
MMR <input type="checkbox"/> MMRII(Merck) born after 1957, (0,4wks)			0.5 ml SC	Left Right
Pneumonia <input type="checkbox"/> Prevnar20 (Pfizer) for adults >50yrs or chronic health <input type="checkbox"/> Capvaxive (Merck) for adults >50yrs or chronic health			0.5 ml IM	Left Right
RSV <input type="checkbox"/> AREXVY (GSK) >50 <input type="checkbox"/> ABRYSVO (PFIZER) >50			0.5 ml IM	Left Right
TDAP <input type="checkbox"/> Boostrix (GSK) 10+ <input type="checkbox"/> Adacel(SP) 10y-64y, 1 every 5-10yr			0.5 ml IM	Left Right
Shingles <input type="checkbox"/> Shingrix (GSK) 0 & 2-6mos for adults >50 or chronic health			0.5 ml IM	Left Right

Nurse Signature: _____ RN Date: _____ Payment Amount: CASH ZELLE CHECK# _____ OTHER: INSUR BILL