Site ID:_____

Vaccine Informed Consent

Personal Information

First Name:	Last Name:	Date of Birth: / /
Age: Phone Number:	Email:	
Mailing Address:		
City: State:	Zip Code:	

Insurance Information

Insurance Carrier:	Cardholder ID:	Group #:
Medicare ID:	SSN:	Tricare Sponsor SSN:
Self Pay: Cash ☐ Check ☐ Amount Paid:		

Screening Questions

	Yes	No
1. Do you have any of the following symptoms: Fever, cough, shortness of breath, sore throat, body aches, vomiting or diarrhea?	☐	☐
2. Do you have any allergies to foods, medications, latex, or vaccine components? (example: polyethylene glycol, polysorbate, eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal) If yes, please list_____	☐	☐
3. Have you every had a serious reaction to an immunization?	☐	☐
4. Have you every experienced seizures, Gillian-Barret syndrome, or any other neurological conditions?	☐	☐
5. Are you currently pregnant or breastfeeding?	☐	☐
6. Have you received any vaccines or skin tests in the past eight weeks? If yes, please list_____	☐	☐

Vaccines requested at this clinic : Influenza ☐ Prevnar 20(pneumonia) ☐ MMR(measels, mumps, rubella) ☐ COVID ☐
TDAP ☐ Shingles ☐

I understand that my health insurance will be billed as a courtesy and I am responsible for payment of any charges unpaid by my insurance. I acknowledge that I have been given a copy and have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s) indicated. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) indicated to be given to me or the person named above for whom I am authorized to make this request. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I understand that Diversified Solutions enters immunization information into the Arizona State Immunization Information System (ASIIS). I hereby authorize Diversified Solutions, to release this information to my healthcare provider(s), and insurance provider.

Signature:_____ **Date:**_____

CLINICIAN SECTION:

I attest that I have reviewed patient screening questions, allergies, and have reviewed VIS with the patient. I have verified that the immunizations are indicated based on patient age and condition and are the vaccines that have been requested by the patient.

Vaccine	Brand	Dose	Lot #	Expiration	Site
					Left Right Deltoid Ventrogluteal Vastus Lateralis
					Left Right Deltoid Ventrogluteal Vastus Lateralis
					Left Right Deltoid Ventrogluteal Vastus Lateralis
					Left Right Deltoid Ventrogluteal Vastus Lateralis

Clinician Signature:_____ **Date:**_____