Informed Consent for Immunization

Last Name	First Name	Middle	Date of Birth	Age	Sex Assigned at Birth (M / F)

Home Address	City	State	Zip	Phone # ☐ Home ☐ Mobile
				( ) -

Vaccine(s) requested: Flu ☐ COVID-19 ☐ Pneumonia ☐ Shingles ☐ Hepatitis B ☐ Tetanus/Whooping Cough ☐ RSV ☐ Hepatitis A ☐ HPV ☐ Meningitis ☐ MMR ☐ Other: _____

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

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

If less than 66 pounds list weight: ____Lbs.

Which arm do you prefer for vaccine? Left ☐ Right

Email address: _____

Primary Care Provider Name: _____

Phone: _____ **Address**: _____

Medicare patients only: Last 4 digits of SSN: _____

Medicare Part B ID#: _____

	Screening Questions	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 (e.g. Guillain-Barré Syndrome)?	☐	☐
4.	For women: Are you pregnant, breastfeeding or are you considering becoming pregnant in the next month? **If pregnant,** gestational week: _____	☐	☐
5.	**Check all that apply to you:** Asthma/lung disease Diabetes ☐ Heart disease Tobacco smoker Seizure disorder/brain disorder Kidney disease/dialysis Liver disease Asplenia Thymus gland removed or problems with your thymus such as myasthenia gravis, DiGeorge syndrome, or thymoma? *(yellow fever only)* Currently taking antibiotics or antimalarial medications? (oral typhoid only) History of thrombocytopenia or thrombocytopenia purpura? *(MMR® II only)* Hospice Weakened immune system (e.g. cancer, HIV, active shingles, oral steroids, anticancer or antiviral drugs, blood transfusion or products, immune globulin, radiation therapy) Received any vaccination in the past 4 weeks? If yes, please list: _____		
6.	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		

	Immunization Needs	Yes	No	Unsure
7.	**Date of last:** Flu vaccine _____ COVID-19 vaccine _____			
8.	Have you ever received a PNEUMONIA vaccine? If yes, when and what kind(s)? _____	☐	☐	☐
9.	Patients **over** 60 years old: Have you ever received an RSV vaccine?	☐	☐	☐
10.	Patients **over** 49 years old **or** immunocompromised: Have you ever received the SHINGLES vaccine? If so, what date(s): _____	☐	☐	☐
11.	Patients **under** 66 years old OR healthcare workers: Have you received an MMR (Measles, Mumps, Rubella) vaccine?	☐	☐	☐
12.	Patients **under** 59 years old OR healthcare workers: Have you received a full hepatitis B vaccine series?	☐	☐	☐
13.	Patients **under** 46: Have you received the full HPV (Human Papillomavirus) vaccine series?	☐	☐	☐
14.	Patients **under** 43 years old: Have you received 2 doses of varicella ("Chicken Pox") vaccine?	☐	☐	☐
15.	Patients aged 11 to 23: Have you received a meningitis vaccine?	☐	☐	☐
16.	How many years has it been since your last TETANUS vaccine?	_____ years		

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. If I am receiving a flu vaccination and it is prior to September 1st, I am either a parent signing on behalf of my child receiving the vaccine, pregnant in my third trimester, or I am unable to return at a later date. 2) I authorize Albertsons Companies to submit a claim for reimbursement on my behalf to Medicare or any other contracted third-party payor, including my employer if they are paying directly for my vaccination; 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.). For minor's parent or guardian, below consent confirms receipt of written notice to visit a pediatrician annually.*

X _____

Signature of Patient or Parent/Guardian of Minor Patient (put relationship to minor) **Printed Name** **Date**

Below for Pharmacy Use Only: ***WA ONLY*: Substitution Permitted**: _____ **Dispense as Written**: _____

Vaccine Name	Lot #	Expiration Date	Manufacturer	Dose (ml)	Dose #	Route	Site (circle)	VIS/EUA Pub. Date	F/U Appt Date/Time
COVID-19(_____)					*N/A*	*IM*	*R / L Deltoid*		
Flu (_____)				*0.5*	*N/A*	*IM*	*R / L Deltoid*		
Shingrix®			***GSK***	*0.5*	❒ 1 ❒ 2	*IM*	*R / L Deltoid*	***2/4/2022***	
							R / L _____		
							R / L _____		
							R / L _____		

Ordering RPh Signature: _____

Name of Administrator: _____

Admin/VIS Provided Date: _____ ❒ **NPP Offered**

Counseling (Please circle): Accepted / Declined

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

Medical (Name, ID#, Group#): _____

❒ **Offsite Clinic** **Clinic Name**: _____ **Clinic Address**: _____

Appt Date: _____ **Appt Time:** _____ **Administration time (OR Only):** _____