Informed Consent for Immunization

Vaccine(s) Requested:

Section A: Patient Information *(required)*

To ensure accurate billing and available insurance coverage, please complete the information below **exactly** as it appears on your insurance card or as your insurance has on file for you.

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

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

Do you have a Primary Care Provider?
(please circle) Yes No

Primary Care Provider Name

Primary Care Phone # ( ) -

Section B: Insurance Information *(if applicable)*

Immunizations may or may not be covered by your insurance. We will verify eligibility under your plan and attempt to collect payment from your insurance for all immunizations. If we are unable to confirm eligibility, you may still opt to receive it at our pharmacy and pay for it yourself or your insurance may cover administration of the vaccine by your physician. You are responsible for payment for products or services you receive that are not paid for by your plan. Please provide your insurance information where indicated on this form.

Note for patients with Medicare: To receive the flu vaccine at no charge at the pharmacy, you must have traditional Medicare Part B, Railroad Medicare, or select Medicare HMO plans. If you have a Medicare HMO plan, it must be a plan that has contracted with the pharmacy to provide immunizations.

Primary Insurance Name	Insurance or Medicare B ID # *(include letters)*	Insurance Group # *(include letters)*

Insurance BIN #

Section C: Informed Consent *(required)*

By my signature below, I consent to the administration of the vaccine(s) requested by a pharmacist employed by Albertsons Companies or one of its affiliated pharmacies or a student pharmacist supervised by a pharmacist employee when permitted by state law. I also release Albertsons Companies and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including any act of omission or commission that may arise from or as a result of my receipt of this vaccination. I understand that:

1. I have voluntarily chosen to receive the vaccination.
2. I am of legal age and authorized to execute this consent form or I am not of legal age and have obtained signed consent of parent or guardian.
3. I will immediately alert the pharmacist of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine.
4. I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I understand that if I experience any side effects, I am responsible for following up with my physician at my expense.
5. I have been advised that I should remain in the area for 15 minutes after vaccination for observation.
6. 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 about the vaccine(s), and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s).
7. I understand that my receipt of this vaccination[1] 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 Dept. of Health, if applicable, and I authorize these disclosures.

[1]Including any vaccination that may be used for treatment of the HIV virus, a related condition, or any other vaccination granted additional privacy protections under state or federal law.

X

Signature of Patient or Parent/Guardian of Minor **Date**

HIPAA Notice Received? □ Yes
__________ **(Please initial)**

Section D: Vaccine History *(required)*

	Please answer these questions by checking the boxes.	Yes	No	Unsure
1.	How long has it been since your last TETANUS shot?	___yrs		❒
2.	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 the PNEUMOCOCCAL vaccine? If yes, when? _______________	❒	❒	❒
3.	Patients 60 years of age or older: Have you ever received the SHINGLES vaccine?	❒	❒	❒

Section E: Screening Questionnaire *(required)*

	Please answer questions by checking the boxes.	Yes	No	Unsure
All Vaccines				
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?	❒	❒	❒
Live Vaccines (chickenpox, FluMist®, MMR® II, oral typhoid, shingles, yellow fever) *Additional questions for those receiving a live vaccine.*				
7.	Have you received any vaccination in the past 4 weeks? If yes, please list:	❒	❒	❒
8.	Do you have cancer, leukemia, HIV, active shingles or any other immune system problem?	❒	❒	❒
9.	Do you take prednisone, oral steroids, anticancer or antiviral drugs or medications that affect the immune system?	❒	❒	❒
10.	During the past year, have you received a transfusion of blood or blood products, been given a medicine called immune (gamma) globulin, or had radiation therapy?	❒	❒	❒
11.	Have you had your thymus gland removed or a history of problems with your thymus such as myasthenia gravis, DiGeorge syndrome, or thymoma? *(Yellow fever only)*	❒	❒	❒
12.	Are you currently taking any antibiotics or antimalarial medications? *(Oral typhoid only)*	❒	❒	❒
13.	Do you have a history of thrombocytopenia or thrombocytopenia purpura? *(MMR® II only)*	❒	❒	❒
14.	Do you have a nasal condition serious enough to make breathing difficult, such as a very stuffy nose? *(FluMist® only)*	❒	❒	❒
15.	For age 18 and younger: Are you receiving aspirin or aspirin containing therapy? *(FluMist® only)*	❒	❒	❒

---------------------- BELOW LINE FOR PHARMACY USE ONLY ----------------------

Please document all vaccines that are administered.					
Vaccine Name	*Flu (___________)*	*Fluzone® HD*	*Zostavax®*		
Lot					
Expiration Date					
Manufacturer		*Sanofi*	*Merck*		
Dose (mL)	*0.5*	*0.5*	*0.65*		
Route	*IM*	*IM*	*SQ*		
Site *(circle)*	*R / L Deltoid*	*R / L Deltoid*	*R / L PLUA*	*R / L (______)*	*R / L (______)*
VIS Publication Date	*8-7-15*	*8-7-15*	*10-6-09*		

Signature of RPh: ________________________ **Intern Initials:** _________ **Date VIS Given to Patient:** ___________________