Pharmacist Verified_______

IMMUNIZATION CONSENT FORM

(Legal) First Name: _______________ **MI:** ____ **Last Name:** ____________________**SSN**__________________

Date of Birth:______ /_______ /______ **Gender:** ☐ Male ☐ Female **Phone #:** _______________________

Street Address: ________________________________ **P.O. Box** ___________ **Apt. No.** ________________________

City: ____ **State:** ____________ **Zip Code:** __________________

Race: ☐White ☐Hispanic/Latino ☐Black/African American ☐Native American /Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐Other

Vaccination(s) Needed: FLU COVID-19 PNEUMONIA T-DAP SHINGRIX HEP-B HEP-A RSV

Screening Questions:	Please Circle:	
Have you had a previous COVID-19 vaccine? If yes, the date of most recent?	**Yes**	**No**
Have you had any other vaccines within the past 4 weeks?	**Yes**	**No**
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?	**Yes**	**No**
Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component, injectable therapy, food, medication or latex? Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness.	**Yes**	**No**
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	**Yes**	**No**
Do you have a history of developing Guillain-Barre Syndrome?	**Yes**	**No**
Have you had a seizure or a brain or other nervous system problem?	**Yes**	**No**
Are you immunocompromised, have cancer, chronic kidney, lung, heart disease, sickle cell, severe obesity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy (for example, cortisone, prednisone, or anticancer therapy? These individuals may still receive COVID-19 vaccine or other vaccines unless otherwise contraindicated	**Yes**	**No**
For COVID-19: Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Vaccination should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced immune responses.	**Yes**	**No**
For Women: Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive COVID-19 vaccine or some other vaccines; a discussion with your healthcare provider can help make informed decision.	**Yes**	**No**

Release, Assignment, Consent and Waiver: I consent to the staff to administer the vaccinations listed below to the individual named above. I have reviewed the vaccine information sheet(s) and/or the COVID-19 EUA and understand the benefits and risks of receiving the medication(s) and choose to assume this risk. I fully release and discharge the **standing order physician and/or pharmacist** from any illness, injury , loss or damage that may result from any non-COVID vaccines, and release and discharge the pharmacy, it's affiliations and their officers and employees from any illness, injury , loss or damage that may result from any vaccines given. I acknowledge that I have received a copy of the pharmacy's privacy practices according to HIPAA. I consent to the release of medical information when necessary for billing, reimbursement and medical protocol. I also allow for the pharmacy to report any medications received to the state vaccine registry. I am aware that an immunization certified student pharmacist might be administering the vaccination(s)

***Signature of Patient/Parent/Guardian**_____________________________________ Date_____________________

****For Ages Under 18**** I acknowledge having received information on the importance of Annual Well Child Visits ** **(Initial Here)**_________ **

****BOOSTER: I attest that I qualify for a COVID-19 booster according to the guidelines set forth by the CDC**(Initial Here)**__________**

INSURANCE INFO **PLEASE PROVIDE**

COPY OF INSURANCE CARD REQUIRED FOR IMMUNIZATION

Medicaid/ARKids#____________________

Insurance: ID#________________________**RxBIN#**______________**RxGROUP#**____________**RxPCN#**__________

****Vaccine Information Statement and/or EUA Fact Sheet for COVID-19 made available to patient. Provider Privacy Notice is available at pharmacy.**

Vaccine Administered:	Route	Inj Site	Dose (mL)	Lot Number	Exp. Date	VIS Date
	IM SQ	**LD RD**				
	IM SQ	**LD RD**				

Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA
Route Codes: IM = Intramuscular, SQ = Subcutaneous **Covid-19 Vaccine Codes:** Pfizer-BioNTech=PFR, Moderna=MOD, Novavax=NVX

Signature and Title of Vaccine Administrator: ____**Date Administered**_________/_________/________