2020-2021 Informed Consent to Receive Vaccines

First Name: _____ **Last Name:** _____ **Date of Birth:** _____ **Age:** ____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (_____) _____ **Select one:** ☐ **Mobile** ☐ **Land line**

Drug Allergies: _____

Physician: _____ **Physician Phone: (_____)** _____

Physician Address: _____

Please complete this section on the day of your immunization. The pharmacist will review your responses and determine your eligibility for receiving an immunization:

1) Have you had direct, close contact with someone who has a positive test for COVID-19 in the past 14 days? ☐ YES ☐ NO
2) Have you had any of the following symptoms in the previous 14 days?

Fever of 100.4°F or higher when not using any fever-reducing medication	☐ YES ☐ NO
Cough	☐ YES ☐ NO
Difficulty breathing or shortness of breath	☐ YES ☐ NO
Other respiratory illness	☐ YES ☐ NO
Sore throat	☐ YES ☐ NO
Diarrhea	☐ YES ☐ NO

MEDICARE / INSURANCE INFORMATION

Immunizations may or may not be covered by your prescription insurance. To be eligible to receive flu vaccination at no charge at the pharmacy you must have traditional **Medicare Part B**, **Railroad Medicare Card**, or **select Medicare HMO plans**. If you have a **Medicare HMO plan,** it must be a plan that has contracted with us to provide immunizations. We will need to verify eligibility with the plan for all immunizations. If we are unable to confirm eligibility, you may need to receive the vaccination from your physician OR you may elect to pay for it yourself to receive it at our pharmacy. Please provide your insurance billing and patient information below. You must list your name exactly as it appears on your Medicare or insurance card. Please provide the date of birth and street address that Medicare or your insurance has on file for you.

Incorrect information can result in Medicare or your HMO rejecting payment. If Medicare or your HMO plan does not cover the immunization, you will be required to pay for the immunization.

Insurance name (Medicare, Senior Dimensions, etc.): _____

BIN: _____ PCN: _____

Group #: _____ ID # (include any letters): _____

Please initial that you have read and understand the information above _____

I have read, or have had read to me, the provided Vaccine Information Statement(s) ("VIS"). 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). I consent to the administration of the vaccine(s) requested. I authorize this information to be forwarded to my primary care physician, the authorizing physician, or the local Dept. of Health, if applicable. I agree to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); SUPERVALU INC.; the subsidiaries and affiliates of SUPERVALU INC.; the respective directors, officers, employees, and agents of SUPERVALU INC. and its subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability that might arise from this vaccination.

By providing my home, work and/or cellular telephone number, I authorize Supervalu, Inc. and its agents to contact me at the number(s) provided, including by calling or texting me using an autodialer or pre-recorded messages, to communicate with me about any of the pharmacy products or services that I have received from Supervalu, Inc. This includes, but is not limited to, contacting me about refill reminders and when future vaccines are due for administration. I understand that message and data rates may apply and that I will have the option of stopping or opting-out of receiving future messages. I understand that I am not required to allow Supervalu, Inc. and its agents to contact me at the number(s) provided above in order to purchase products or services from Supervalu, Inc.

_____ _____

Patient Signature **Date**

Please initial that you received our HIPAA Notice of Privacy Practices

_____ (initials)

Patient Name	Patient DOB

Please answer yes or no to the questions below. If any questions are unclear, please ask for help.

		Yes	No
1	Do you have a fever, diarrhea, or vomiting today?	☐	☐
2	Are you allergic to eggs, Baker's yeast, preservatives (i.e. sulfites), thimerosal, streptomycin, neomycin, Arginine, gelatin or **latex?**	☐	☐
3	Have you ever had a severe reaction to any vaccine which required medical care?	☐	☐
4	Are you or anyone in your home, or anyone you take care of being treated with chemotherapy, radiation for cancer, have HIV/AIDS or any immune deficiency disorder?	☐	☐
5	Do you have a long-term health problem such as heart disease, lung disease, asthma, kidney disease, diabetes, or blood disorders?	☐	☐
6	Have you had Immune (gamma) Globulin or a transfusion of blood or plasma in the past year?	☐	☐
7	Have you had Guillain-Barre Syndrome, a condition which causes paralysis?	☐	☐
8	Are you taking any blood-thinning medications (i.e. aspirin, warfarin, etc)?	☐	☐
9	Are you on immunosuppressive therapy, including high-dose corticosteroids?	☐	☐
10	Have you received any vaccines in the past 4 weeks?	☐	☐
11	**For women**: Are you pregnant or planning pregnancy in the next month?	☐	☐

NOTE: The pharmacist will review these questions with you before giving the immunization. Based on your answers, we may refer you to speak with your physician to make sure the vaccine is right for you. If you have ever experienced syncope (fainting) after immunization administration in the past, please notify the pharmacist prior to administration.

VACCINE INFORMATION (Office use only)

Vaccine	Lot #	Exp. Date	Manufacturer	Dose (ml)

Route	Right or Left Arm Admin. Site	Admin / VIS given date	VIS publication date

ADMINISTRATOR*	Patient Age (Verification Purposes)	STORE # (Where pt received vaccine)

Vaccine	Lot #	Exp. Date	Manufacturer	Dose (ml)

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*By signing as administrator, you are confirming that contraindications and side effects have been reviewed and a current VIS was provided to the patient receiving vaccine.