Informed Consent for Immunization

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

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 #
		( ) -

If known, please provide date when vaccine was last received:

Flu _____ Pneumonia _____ Shingles _____ Tetanus _____ Other _____

Screening Questionnaire: *Please answer questions by checking the boxes.*

All Vaccines		**Yes**	**No**
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, cholera, intranasal flu, MMR® II, oral typhoid, yellow fever, and Zostavax®)		**Yes**	**No**
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.	For age under 18: Are you taking aspirin or an aspirin containing medication? *(intranasal flu only)*	❒	❒

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, where permitted by law, employed 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. 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 of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination and understand that I am obligated to pay for all products and services received. 2) I may be responsible for payment after the date of service if the product or service is billed to my medical benefit. 3) I am of legal age and authorized to execute this consent form or I am not of legal age and have obtained the signed consent of a parent or guardian. 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 have been advised that I should remain in the area for 15 minutes after the vaccination for observation. 7) 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, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). 8) 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.

X _____ _____

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

HIPAA Notice Received? □ Yes

_____ **(Please initial)**

For Pharmacy Use Only

Vaccines Recommended but NOT Given: ❒Prevnar® ❒Pneumovax® ❒Shingrix® ❒Tdap ❒Other _____ Pt. Initials (to decline) _____

Vaccine Name	Lot #	Expiration Date	Manufacturer	Dose (ml)	Route	Site (circle)	VIS Publication Date
Flu (_____)				*0.5*	*IM*	*R / L Deltoid*	*8-7-15*
Shingrix®			*GSK*	*0.5*	*IM*	*R / L Deltoid*	*2-12-18*
						R / L _____	
						R / L _____	

Signature of RPh: _____ **Initials of Administrator:** _____ **VIS Given and Administration Date:** _____

Billing Info *(off-site only):* ❒Medicare (ID# including letters) or Medical (Name, ID#, Group#, Payer ID if UHC) _____

❒Prescription (BIN, PCN, Group#, ID#, Person Code) _____