2015-2016 Informed Consent to Receive Vaccines

List your name exactly as it appears on your Medicare or other insurance card. Provide the date of birth and street address that your insurance has on file for you. Providing incorrect information may cause your insurance to reject payment.

PATIENT INFORMATION

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

Street Address: _____**Age:**_____

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

Phone: (_____)_____ **Male / Female (circle one)**

Drug Allergies: _____

When did you last receive the following vaccines?

Hepatitis B	Date _____/_____/_____	____Never/Unsure	Tetanus	Date _____/_____/_____ ____Never/Unsure
Influenza (flu)	Date _____/_____/_____	____Never/Unsure	Whooping cough	Date_____/_____/_____ ____Never/Unsure
Pneumonia	Date _____/_____/_____	____Never/Unsure	Other _____	Date_____/_____/_____ ____Never/Unsure
Shingles	Date _____/_____/_____	____Never/Unsure		

PHYSICIAN INFORMATION

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

Physician Address: _____

INSURANCE INFORMATION

Important Notice: 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 below.

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.

Insurance name (i.e. Medicare B, Aetna, etc.): _____

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

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 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. 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.

Please initial that you received our HIPAA Notice of Privacy Practices

_____ (initials)

_____ _____

Patient/Parent/Guardian Signature **Date**

[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.

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

	YES	NO
1. Do you have fever, diarrhea or vomiting today?		
2. Are you allergic to eggs, Baker's yeast, preservatives (e.g. sulfites), thimerosal, streptomycin, neomycin, Arginine, gelatin or latex?		
3. Have you ever had a serious reaction to any vaccine which required medical care?		
4. Are you or anyone on 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, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g. diabetes) or anemia or other blood disorder?		
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 may cause paralysis?		
8. Are you taking in 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?		

Patient name:

Patient DOB:

NOTE: The pharmacist will review these questions with you before giving the immunization. Based on your answers, they may refer you to speak with your physician to make sure the vaccine is right for you.

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* **STORE # (Where pt received vaccine)**

_____ _____ _____ _____ _____
Vaccine **Lot #** **Exp. Date** **Manufacturer** **Dose (ml)**

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

_____ _____
ADMINISTRATOR* **STORE # (Where pt received vaccine)**

*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.