Immunization informed consent

First name:______________ **Last name**:________________________ **Date of birth**:______________ **Age:**____
Gender: _______ Home address:____ City:______________
State:____ ZIP code:____________Phone:_________________________
Email address________________________________
Medicare ID#:________________________ Last 4 digits of SSN:__________
Medical Plan (Name, ID#, Group#, Payer ID - if UHC): ____________________
RxBIN#: ____________________________ PCN#: ________________ Group#: __________
Insurance ID#:__________________________________
Race (circle): Asian / Black or African American / Hispanic / American Indian / Caucasian / Pacific Islander
Two or More / Other: _______________________
Ethnicity (circle): Hispanic or Latino / Non-Hispanic or Latino / Decline to State (Unknown)

We will send vaccination information from this visit to your doctor/primary care provider using the contact information provided below.
Doctor / Primary care provider name: ____
Address: ______________________________________ City: ______________ State: _____
ZIP Code: ______________ Phone: ________________

I want to receive the following vaccination(s):

____

The following questions will help us determine your eligibility to be vaccinated today.

	YES	NO	DON'T KNOW
1. Do you feel sick today?			
2. Do you have any health conditions, such as heart disease, diabetes or asthma? If yes, please list _____________________________________			
3. Do you have allergies to latex, medications, food or vaccines (examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list ____			
4. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?			
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem?			
6. For women: Are you pregnant or considering becoming pregnant in the next month?			
7. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19 within the last 90 days?			

For chickenpox, MMR® II, shingles, Vaxchora®, yellow fever only: Only answer these questions (8-16) if you are receiving any vaccinations listed above:	YES	NO	DON'T KNOW
8. Have you received any vaccinations or skin tests in the past four to eight weeks? If yes, please list: ____________________			
9. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)?			
10. Are you currently on home infusions, weekly injections such as Humira® (adalimumab), Remicade® (infliximab) or Enbrel® (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?			
11. Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?			
12. Have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin in the past year?			
13. Do you have a history of thrombocytopenia or thrombocytopenia purpura? (MMR® II only)			

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to Vibrant Care Pharmacy and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for observation for approximately 15 minutes after administration. If I leave the area without waiting, I acknowledge that I am doing that at my own risk and against the advice of the professional who administered the vaccine. I release Vibrant Care Pharmacy and its affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting or arising from my receipt or the minors receipt of this vaccination. I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("California Immunization Registry - CAIR") and the applicable Provider may disclose my vaccination information to the CAIR for purposes of public health reporting, or to my healthcare providers enrolled in the CAIR for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the applicable Provider: (a) the disclosure of my vaccination information by the applicable Provider to the CAIR from sharing my vaccination information with any of my other healthcare providers enrolled in the CAIR. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I further authorize the applicable Provider to: (a) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice.

Patient signature:____ Date:_____________

(Parent or guardian, if minor)

Name of Administrator: ________________________ License#_____________Administration Date:_____________

RPH Counseling offered (Please circle): Accepted / Declined

RPh Signature [Indicates (1) VIS/EUA Provided (2) Counseling Offered and (3) Patient Eligibility Verified]:

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