Informed Consent for Immunization

Vaccine(s) Requested:

Section A: Patient Information *(required)*

To ensure accurate billing and available insurance coverage, please complete the information below **exactly** as it appears on your insurance card or as your insurance has on file for you.

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 #**

Section B: Insurance Information *(if applicable)*

Immunizations may be covered on your prescription or medical benefit. Our pharmacy can bill prescription plans and many medical plans for vaccine services. We will attempt to verify eligibility under your plan and collect payment from your insurance for all immunizations. If we are unable to confirm eligibility, you may still choose to receive the vaccine at our pharmacy and pay out-of-pocket. Some insurance plans may only cover administration of the vaccine by your physician or HMO/IPA provider. You are responsible for payment for services you receive that are not paid for by your plan. If we bill your medical plan, your health plan may not provide complete deductible or coverage information at the time of service. You may receive an invoice from us after your health plan processes the claim for the amount that your plan indicates is your responsibility to pay.

Note for patients with Medicare: To receive the flu or pneumonia vaccine at no charge, you must have traditional Medicare Part B, Railroad Medicare, or select Medicare HMO plans. If you have a Medicare HMO plan, vaccines may be covered under your prescription or medical benefit. To bill your Medicare HMO plan directly, the plan must be contracted with the pharmacy.

Prescription Plan Name	Rx BIN #	Rx PCN #	Group # *(include letters)*	ID # *(include letters)*

Medical Plan Name/Medicare B	Group # *(include letters)*	ID # *(include letters)*	Payer ID *(if available)*

Section C: Informed Consent *(required)*

By my signature below, I consent to the administration of the vaccine(s) requested above 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.
2. I am of legal age and authorized to execute this consent form or I am not of legal age and have obtained signed consent of parent or guardian.
3. I will immediately alert the pharmacist of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine.
4. I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I understand that if I experience any side effects, I am responsible for following up with my physician at my expense.
5. I have been advised that I should remain in the area for 15 minutes after vaccination for observation.
6. 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 about the vaccine(s), and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s).
7. 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.

[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.

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

HIPAA Notice Received? □ Yes

_____ **(Please initial)**

Section D: Vaccine History *(required)*

	Please answer question by checking the boxes.	Yes	No	Unsure
All Vaccines				
1.	How long has it been since your last TETANUS shot?	_____ years		❒
2.	Please check all that apply to you: ❒Asthma ❒Diabetes ❒Heart Disease ❒Tobacco Smoker ❒ Age 65 years or older If you checked any of the above, have you ever received the PNEUMOCOCCAL vaccine? If yes, when? _____	❒	❒	❒
3.	Patients 60 years of age or older: H ave you ever received the SHINGLES vaccine?	❒	❒	❒

Section E: Screening Questionnaire *(required)*

	Please answer questions by checking the boxes.	Yes	No	Unsure
All Vaccines				
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, MMR® II, oral typhoid, shingles, yellow fever, cholera) *Additional questions for those receiving a live vaccine.*				
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)*	❒	❒	❒

---------- **BELOW LINE FOR PHARMACY USE ONLY** ----------

Please review Section D and document recommendations. Patient to initial to decline.

Vaccine	Yes	No	Pt. Initial	Vaccine	Yes	No	Pt. Initial
Tetanus	❒	❒	_____	*Prevnar13®*	❒	❒	_____
Zostavax®	❒	❒	_____	*Pneumovax®*	❒	❒	_____

Please document all vaccines that are administered.

Vaccine Name	*Flu (_____)*	*Fluzone® HD*	*Zostavax®*		
Lot					
Expiration Date					
Manufacturer		*Sanofi*	*Merck*		
Dose (mL)	*0.5*	*0.5*	*0.65*		
Route	*IM*	*IM*	*SQ*		
Site *(circle)*	*R / L Deltoid*	*R / L Deltoid*	*R / L PLUA*	*R / L (_____)*	*R / L (_____)*
VIS Publication Date	*8-7-15*	*8-7-15*	*10-6-09*		

Signature of RPh: _____ **Initials of Administrator (if different than RPh):** _____ **VIS Given and Administration Date:** _____