Informed Consent for Immunization with Inactivated & Live Vaccines

❒ M ❒ F

Last Name | **First Name** | **Middle** | **Date of Birth** | **Age** | **Sex Assigned at Birth**

( ) -

Home Address | **City** | **State** | **Zip** | **Phone #** ❒ **Home** ❒ **Cell**

Vaccine(s) requested: ❒ Flu ❒ COVID-19 ❒ Pneumonia ❒ Shingles ❒ Hepatitis B ❒ Tetanus/Whooping Cough ❒ Other(s): _____ _____

Ethnicity: ❒ Hispanic or Latino ❒ Non-Hispanic or Latino ❒ Decline to State (Unknown)

If less than 66 pounds list weight: ____Lbs.

Race: ❒ Asian ❒ American Indian ❒ Pacific Islander ❒ Black or African American ❒ Caucasian ❒ Two or More ❒ Other

Which arm do you prefer for vaccine? ❒ Left ❒ Right

Email address: _____

Medicare patients only: Last 4 digits of SSN: _____

Medicare Part B ID#: _____

Primary Care Provider Name: _____

Phone: _____ **Address**: _____

Screening Questions		**Yes**	**No**
1.	Are you sick today?	❒	❒
2.	Do you have any allergies to medications, food or vaccines? If yes, please list:_____	❒	❒
3.	Have you ever had a serious reaction or fainted after receiving a vaccination (e.g. Guillain-Barré Syndrome)?	❒	❒
4.	For women: Are you pregnant or are you considering becoming pregnant in the next month?	❒	❒
5.	Check all that apply to you: ❒ Asthma or lung disease ❒ Diabetes ❒ Heart Disease ❒ Tobacco Smoker ❒ Seizure disorder or a brain disorder (tdap only) ❒ Have medical condition(s) or take medication(s) that weaken your immune system? (e.g. cancer, leukemia, HIV, active shingles, oral steroids, anticancer or antiviral drugs)		
6.	Please indicate which vaccine(s) you would like more information about? ❒ Hepatitis A ❒ MMR (Measles, Mumps, Rubella) ❒ Travel Vaccines ❒ Childhood Vaccines ❒ Other:_____ ❒ Unsure: would like an assessment done of potential vaccination gaps or needs		

Immunization Needs		**Yes**	**No**	**Unsure**
7.	Have you ever received a PNEUMONIA vaccine? If yes, when and what kind(s)? _____	❒	❒	❒
8.	Patients 50 and older **or** immunocompromised: Have you ever received the SHINGLES vaccine? If so, what date(s): _____	❒	❒	❒
9.	Patients 19 to 59 years old: Have you received a hepatitis B vaccine series?	❒	❒	❒
10.	Patients under 46: Have you received the HPV (Human Papillomavirus) vaccine?	❒	❒	❒
11.	Patients aged 11 to 23: Have you received a meningitis vaccine?	❒	❒	❒
12.	How many years has it been since your last TETANUS vaccine?	_____ years		❒

LIVE VACCINES ONLY (chickenpox, cholera, intranasal flu, MMR® II, rotavirus, oral typhoid, and yellow fever)		**Yes**	**No**
13.	Have you received any vaccination in the past 4 weeks? If yes, please list: _____	❒	❒
14.	During the past year, have you received a blood transfusion, blood products, been given a medicine called immune (gamma) globulin, or had radiation therapy?	❒	❒
15.	Have you had your thymus gland removed or problems with your thymus such as myasthenia gravis, DiGeorge syndrome, or thymoma? *(yellow fever only)*	❒	❒
16.	Are you currently taking any antibiotics or antimalarial medications? *(oral typhoid only)*	❒	❒
17.	Do you have a history of thrombocytopenia or thrombocytopenia purpura? *(MMR® II only)*	❒	❒
18.	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, or other authorized person, where permitted by law or state/federal guidance, employed or contracted 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. The above information is true and correct. I attest I meet eligibility criteria for the vaccination (if any); if I am the parent/guardian of the minor patient, I attest the minor patient meets eligibility criteria for the vaccination. 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 or the minor's receipt of this vaccination. I understand: 1) I have voluntarily chosen to receive the vaccination. If I am receiving a flu vaccination and it is prior to September 1st, I am either a parent signing on behalf of my child receiving the vaccine, pregnant in my third trimester, or I am unable to return at a later date. 2) I authorize Albertsons Companies to submit a claim for reimbursement on my behalf to Medicare or any other contracted third-party payor, including my employer if they are paying directly for my vaccination; if the claim is denied, I understand I will be responsible for payment; 3) I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient. 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 should remain in the area for observation for 15 minutes unless I have a history of an immediate allergic reaction of any severity to a vaccine or injectable therapy or if I have a history of anaphylaxis due to any cause, I should remain in the area for observation for 30 minutes after the vaccination. If I leave the area without waiting, I acknowledge that I am doing so at my own risk and against the advice of the professional who administered the vaccine. 7) I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization ("EUA") 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) I have been offered and/or provided a copy of the company's Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA). 9) 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. (*New Jersey Only: I authorize ___ do not authorize ___ reporting of my receipt of this vaccination to my primary care provider I understand that failure to check authorize/do not authorize will serve as authorization.*) *(South Dakota, Maine, Massachusetts, and New Hampshire only: I understand I have the right to object to the sharing of my data to the above-mentioned parties through such registries.). For minor's parent or guardian, below consent confirms receipt of written notice to visit a pediatrician annually.*

X _____

Signature of Patient or Parent/Guardian of Minor Patient (put relationship to minor) **Printed Name** **Date**

Below for Pharmacy Use Only: ***WA ONLY*: Substitution Permitted**:_____ **Dispense as Written**: _____

Vaccine Name	**Lot #**	**Expiration Date**	**Manufacturer**	**Dose (ml)**	**Dose #**	**Route**	**Site** (circle)	**VIS/EUA Pub. Date**
COVID-19(_____)					#____	*IM*	*R / L Deltoid*	
Flu (_____)						*IM*	*R / L Deltoid*	
Shingrix®			***GSK***	*0.5*	❒ 1 ❒ 2	*IM*	*R / L Deltoid*	***2/4/2022***
Prevnar 20®			***Pfizer***	*0.5*	*1*	*IM*	*R / L Deltoid*	
							R / L _____	
							R / L _____	

Ordering RPh Signature:_____

Name of Administrator:_____

Admin/VIS Provided Date: _____ ❒ **NPP Offered**

Counseling (Please circle): Accepted / Declined

RxBIN: _____ **PCN**:_____ **Group #**:_____ **ID#**: _____

Medical (Name, ID#, Group#): _____

❒ **Offsite Clinic** **Clinic Name**: _____ **Clinic Address**: _____

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years and older, pregnant people, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections, and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer, or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

In an average year, **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2. Influenza vaccines

CDC recommends everyone 6 months and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against the influenza viruses believed to be likely to cause disease in the upcoming flu season.

Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**
- Has ever had **Guillain-Barré Syndrome** (also called "GBS")

In some cases, your health care provider may decide to postpone influenza vaccination until a future visit.

Influenza vaccine can be administered at any time during pregnancy. People who are or will be pregnant during influenza season should receive inactivated influenza vaccine.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4. Risks of a vaccine reaction

- Soreness, redness, and swelling where the shot is given, fever, muscle aches, and headache can happen after influenza vaccination.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/flu**.