2012-2013 Informed Consent to Receive Vaccines

PATIENT INFORMATION

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

Street Address: _____

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

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

Drug Allergies _____

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

Physician Address: _____

When did you last receive the following vaccines?	Pneumovax	Date _____/_____/_____	_____ I haven't received
	Influenza	Date _____/_____/_____	_____ I haven't received
	Tetanus	Date _____/_____/_____	_____ I haven't received
	Zostavax	Date _____/_____/_____	_____ I haven't received
	Other_____	Date _____/_____/_____	_____ I haven't received

INSURANCE INFORMATION

Immunizations may or may not be covered by your prescription insurance. To be eligible to receive flu vaccination at no charge at the pharmacy you must have traditional **Medicare Part B**, **COVA Care**, or **COVA Connect**. If you have a **Medicare HMO plan,** it must be a plan that has contracted with us to provide immunizations. We will need to verify eligibility with the plan for all immunizations. If we are unable to confirm eligibility, you may need to receive the vaccination from your physician OR you may elect to pay for it yourself to receive it at our pharmacy. Please provide your insurance billing and patient information below. You must list your name exactly as it appears on your Medicare or insurance card. Please provide the date of birth and street address that Medicare or your insurance has on file for you.

Incorrect information can result in Medicare or your HMO rejecting payment. If Medicare or your HMO plan does not cover the immunization, you will be required to pay for the immunization.

Insurance name (Medicare, Senior Dimensions, etc.):_____

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

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 authorize this information to be forwarded to my primary care physician, the authorizing physician, or the local Dept. of Health, if applicable. 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 Signature **Date**

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

Patient Name

Patient DOB / /

		Yes	No
1	Do you have a fever, diarrhea, or vomiting today?	☐	☐
2	Are you allergic to eggs, Baker's yeast, preservatives (i.e. sulfites), thimerosal, streptomycin, neomycin, Arginine, gelatin or **latex?**	☐	☐
3	Have you ever had a severe reaction to any vaccine which required medical care?	☐	☐
4	Are you or anyone in 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, diabetes, or blood disorders?	☐	☐
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 causes paralysis?	☐	☐
8	Are you taking any 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?	☐	☐

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

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

Vaccine	Lot #	Exp. Date	Manufacturer	Dose (ml)

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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.