Pharmacy

IMMUNIZATION CONSENT FORM

Name:_____ Birth date:____/____/____ Age:_____ Sex: (M/F)_____

Address:_____ City:_____ State:_____ Zip:_____

Phone: (____)_____ Medicare ID# (Including Alpha):_____ Publix Associates only – Personnel Number:_____

Primary Care Provider Name:_____ Which vaccine(s) would the patient like to receive today? **Select all that apply. State restrictions may apply.**

□ Influenza (Flu) □ Hepatitis A (Rx only) □ Hepatitis B (Rx only) □ Hepatitis Combo A&B (Rx only) □ HPV (Rx only)

□ MMR (Rx only) □ Pneumococcal □ Td/Tdap (Rx only) □ Zoster (Shingles) □ Meningococcal □ Others

	Precautions and Contraindications: Please mark YES or NO for each question.	**YES**	**NO**
For Inactive and Live Vaccines	1.Are you 18 years of age or older? (Age restrictions may apply to certain states/vaccines. Consult the pharmacist.)		
	2.Do you have a cold, fever, or acute illness?		
	3.Do you have any allergies to medications, food, or any vaccine? **List:**_____		
	4.Are you allergic to chicken eggs or egg product?		
	5.Are you allergic to Thimerosal (cleaning products or contact lens solution)?		
	6.Have you ever had a serious reaction after receiving a vaccination?		
	7.Have you ever been diagnosed with Guillain-Barre' syndrome? *(for meningococcal)*		
	8.Do you have a seizure, brain, or nerve problem? *(for pertussis)*		
	9.Have you had a physical exam within the last year?		
For Live Vaccines only	10.Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?		
	11.Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation?		
	12.During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?		
	13.For women: Are you pregnant/is there a chance you could become pregnant during the next month?		
	14Have you received any vaccinations in the past 4 weeks?		
	15.For Intranasal Influenza: Do you have a long-term health problem such as heart, lung, kidney, liver, or metabolic disease (e.g. diabetes), neurologic or neuromuscular disease, anemia or other blood disorder?		

If you answered "YES" to question 2-15, you must talk with your pharmacist before being vaccinated.

I voluntarily request and consent that a pharmacist employed by Publix Super Markets, Inc. ("Publix") administer to me the following vaccine(s) ("Vaccine") selected above. I acknowledge that Publix has given me a copy of the Vaccine Information Statement that contains information about the Vaccine including information on certain adverse reactions that I may experience as a result of receiving the Vaccine, and I have carefully read and understand the Vaccine Information Statement. I have had an opportunity to ask the Publix pharmacist any questions about the Vaccine or about information in the Vaccine Information Statement and my questions have been answered to my satisfaction. I have truthfully answered all the questions regarding my medical history that are listed above. I understand that if I answered a question with a "Yes" there is an increased likelihood that I will experience an adverse reaction from the administration of the Vaccine. After careful consideration, I believe that the benefits of receiving the Vaccine outweigh the risks associated with receiving the Vaccine and I have decided to have the Publix pharmacist administer the Vaccine to me. If applicable, I authorize Publix to submit a claim to my insurer for this health care service and authorize an assignment of my insurance benefits under such claim to Publix. I will be financially respons ble for any copays, coinsurance and deductibles for the requested services as well as for any services not covered by my insurance benefits. I authorize Publix to use and/or disclose such information about me, including any medical related information that I provide to Publix or that is created or received by Publix that Publix reasonably determines is necessary to receive payment for its services, carry out my treatment or conduct its health care operations. This authorization includes disclosures to regulatory agencies, Medicare, Medicaid, health plans, pharmacy benefit managers, claims processors, billing companies, interpreters and other persons involved in my treatment, as well as any state immunization registry. I authorize Publix to notify my primary care provider identified above, if any, of the administration of the vaccine to me. Publix shall not, at any time, or to any extent allowable by applicable law, be liable, respons ble, or in any way be accountable for any loss, injury, death, or damage suffered or sustained by me or any other person at any time in connection with, or as a result of, the administration of the Vaccine to me by the Publix pharmacist. I, for myself, my heirs, executors, personal representatives and assigns, hereby release Publix, its employees and contractors, specifically the administering pharmacist, its agents or representatives from any and all claims arising out of, in connection with, or in any way related to my receipt of the Vaccine from Publix as allowed by applicable law. By signing below, I certify that I am the patient or the patient's guardian/personal representative signing on behalf of the patient, and that I have read, understand and agree to all the statements on this form.

_____ _____ _____

Signature of Patient or Legal Guardian | Relation to Patient (if patient) | Date

For Publix Use Only:

Billing (select one):____Medicare_____Cash_____Publix Associate_____Family Member_____Other (Specify:_____)

Vaccine Administration Record

Vaccine Type	Dose	Vaccine			Date Given (mo/day/yr)	Route (IM, SQ)	Site Given (RA, LA)	Vaccine Information Statement	
		Lot #	Expiration	Manufacturer				Date on VIS	Date Given

Primary Care Physician Notification (Required in Georgia)

Notified Physician	Patient does not have primary care physician—provided required paperwork
☐	☐

_____ _____ _____

Printed Name of Pharmacist Administering Vaccine | Title | Pharmacist License #

_____ _____

Pharmacy Address | City, State, Zip

_____

Pharmacy Phone #

_____ _____

Pharmacist's Signature | Drug Protocol # and Physician's Name