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(REQUIRED):_____ Primary Care Physician Name:_____

☐ Influenza (Flu) ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis Combo (A & B) ☐ HPV ☐ Meningococcal

☐ MMR (Rx only) ☐ Pneumococcal ☐ Td/Tdap ☐ Zoster (Shingles) ☐ Other:_____

Precautions and Contraindications: Please mark YES or NO for each question.	**YES**	**NO**
Are you sick today?		
Do you have any allergies to medications, food (e.g. eggs), latex, or a vaccine component (e.g. gelatin, neomycin, polymyxin, yeast, thimerosal, etc.)? If yes, please **list:**_____		
Have you ever had a serious reaction (including fainting) after receiving a vaccination?		
Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a physician's office or hospital?		
Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder?		
Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohn's disease?		
In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroid, or anticancer drugs, or have you had radiation treatments?		
Have you had a seizure, or a brain, or other nervous system problem or Guillain-Barre?		
During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin or an antiviral drug?		
For women: Are you pregnant or is there a chance you could become pregnant during the next month?		
Have you received any vaccinations in the past 4 weeks?		
For Tdap and adult Td (ONLY)—Do you have an open wound, puncture, or tissue tear that prompted you to get a tetanus shot?		
If you answered "YES" to any question, 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 responsible 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. Publix shall not, at any time, or to any extent allowable by applicable law, be liable, responsible, 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 _____ Date _____

For Publix Use Only:

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

Vaccine Administration Record

Vaccine Type	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 North Carolina)

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 _____