Pharmacy

IMMUNIZATION CONSENT FORM

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

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

Phone: (____)_____ Medicare ID# (Including Alpha):_____ Publix Associate Personnel Number :_____

Primary Care Practitioner: _____ Select vaccines to be administered:

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

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

	Precautions and Contraindications: Please mark YES or NO for each question.	**YES**	**NO**
For Inactive and Live Vaccines	For Flu Shot: Are you 12 years of age or older? For Other Vaccines: Are you 18 years of age or older?		
	Are you sick today? • If YES, please answer these additional questions: o Do you have a new fever? YES_____NO _____ o Do you have a cough? YES_____NO _____ o Do you have diarrhea? YES_____NO _____ o Have you been vomiting? YES_____NO _____		
	Do you have any allergies to latex, medications, food, or any vaccine? **List:**_____		
	Are you allergic to chicken eggs or egg product?		
	Are you allergic to Thimerosal (cleaning products or contact lens solution)?		
	Have you ever fainted or felt dizzy after receiving a vaccine?		
	Have you ever had a reaction after receiving a vaccine?		
	Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g. diabetes), or anemia or another blood disorder?		
	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?		
	Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barre' syndrome or other nervous system problems?		
	For women: Are you pregnant or considering becoming pregnant in the next month?		
For Live Vaccines only	Are you currently taking high-dose steroid therapy (prednisone >20 mg/day or equivalent) for longer than 2 weeks?		
	Are you currently on home infusions or weekly injections (such as Remicade, Humira, Enbrel, Cimzia, Simponi, Simponi Area, Xeljanz, Orencia, Arava, Actermra, Cytoxan, Rituxan, adalimumab, infliximab, or etancercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?		
	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?		
	During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?		
	Have you received any vaccinations or skin tests in the past 4 weeks?		
	For Intranasal Influenza: Do you have a long-term health problem such as heart, lung, kidney, liver, or metabolic disease (e.g. diabetes), asthma, neurologic or neuromuscular disease, anemia or other blood disorder?		
	For Intranasal Influenza: Have you ever had a serious reaction to intranasal influenza vaccine (FluMist)?		
	For Intranasal Influenza: Are you older than age 49?		

This pharmacy is providing necessary vaccines to you in a safe and convenient setting in order to promote adherence to current immunization guidelines recommended by the CDC and ACIP. It does not take the place of an ongoing relationship with your primary care provider to address ongoing medical issues and other types of preventive care. We are providing your primary care provider with records of the vaccine(s) administered here so that your medical records may be complete, but be sure to take your personal record with you to your next appointment as well.

Please review the statement below confirming your consent for vaccination and provide the information requested.

I have read, or had explained to me, the Vaccine Information Statement for the selected vaccine. I understand the risks and benefits, and have been provided an opportunity to ask questions, which have been answered to my satisfaction. I wish to receive the vaccine selected above and hereby give consent for the Publix Pharmacist or Pharmacy Intern and Supervising Pharmacist named on the reverse to administer the vaccine and communicate the administration of the vaccine to my primary care practitioner, who is listed above.

I have read, or had explained to me, the Vaccine Information Statement for the Vaccine. 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 l kelihood that I will experience an adverse reaction from the administration of the Vaccine. 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 certify that the information contained on my benefits card and reported to Publix is correct and current and that I am elig ble for the benefits claimed. I understand that Publix is relying on my benefits card and the information that I provide in order to receive payment and that I am responsible for correcting any inaccuracies, errors or omissions. I will be financially respons ble for any copays, coinsurance and deduct bles 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, 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 _____

RC1174

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 Provider Notification (Required in South Carolina)

Staple a copy of the Provider Notification to this hard copy.

Completed	Patient Does Not Have Primary Care Provider
☐	☐

Printed Name of Pharmacist or Intern Administering Vaccine _____ Title _____ Pharmacist or Intern License # _____

Pharmacy Address _____ City, State, Zip _____

Pharmacy Phone # _____

Signature of Pharmacist Administering Vaccine or Signature of Pharmacist Supervising Pharmacy Intern _____ Drug Protocol # and Physician's Name _____

Adverse Reaction Log

(In addition to this Log, Pharmacist or Intern must complete and submit VAERS report)

Date and Time of Adverse Reaction:
Describe Adverse Reaction of the Vaccine(s): (e.g. shortness of breath, angioedema, chest pain, syncope, rash, etc.)
Describe Interventions (include medications and dosage, CPR, etc. for Adverse Reaction:
Disposition: (home, EMS, etc.)

Signature of Pharmacy Intern (if applicable) _____ Signature of Pharmacist or Pharmacist Supervising Pharmacy Intern _____ Date _____

Place a copy of the prescription label here: