

IMMUNIZATION INFORMED CONSENT v 7.1.26

First Name

MI

Last Name

Cell Phone

☐ check to opt out of texts

Date of Birth (mm/dd/yyyy)

Age

M

F

Sex

Home Address

City

State

Zip Code

Rx Insurance (Carrier & ID#)

	YES	NO	??
1. Do you have a fever (>100.4°) or moderate to severe illness today?			
2. Have you received any vaccine in the past 4 weeks? If yes, please list _____			
3. Have you ever had immediate allergy (hives, wheezing, anaphylaxis) to any foods, medications or vaccine? Please list _____			
4. Have you ever fainted or had a serious reaction to any vaccine in the past?			
5. Do you have a seizure disorder, a brain disorder, nervous system disorder, or Guillain-Barre syndrome (a condition causing paralysis)			
6. Have you ever been told you had myocarditis or pericarditis within 3 weeks of receiving a COVID vaccine?			
7. For women: Are you pregnant or considering becoming pregnant in the next month? (NO live vaccines). Gestation week? _____			
8. For the past 3 months, have you taken medications that affect your immune system, such as prednisone or other steroids, anti-cancer drugs; biologic drugs for rheumatoid arthritis, Crohn's disease, psoriasis; or have you had radiation treatments? (NO live vaccines).			
9. Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder? (NO live vaccines).			
10. Have you received a transfusion of blood or blood products, or immune (gamma) globulin in the past year? (NO live vaccine)			
11. If the patient receiving vaccine is under 5 years old, is there a history of asthma or wheezing? (for FluMist® only)			

Immunization Needs: Please check all that apply to you. (Eligibility may depend on your immunization history or risk factors)

Based on the disease state below,

you may be eligible to receive (ages 18 and older):

☐ Diabetes	Flu	COVID	Pneumonia	Shingles	Hepatitis B	Tdap	RSV
☐ Heart Disease							
☐ Asthma/lung disease							
☐ Immunocompromised							
☐ Liver or kidney disease (dialysis)							
☐ Tobacco smoker							

Based on your age below,

you may be eligible to receive:

☐ Age 50 or older	Flu	COVID (65+ every 6 months)	Tdap	Pneumonia	Shingles	RSV (75+ or based on risk)
☐ Age 18-49				HPV (max age 45)	Hepatitis B	Meningococcal B (age 16-23)
☐ Age 11-17				HPV	Meningococcal ACWY (age 11-16); B (age 16-23)	

I certify I am the patient and at least 18 years of age; the legal guardian of the patient; or a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. I have received a Notice of Privacy Practice (HIPAA). I have been provided the vaccine specific Vaccine Information Statement (VIS) or EUA. I have been able 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 understand some vaccines may not be included in the National Vaccine Injury Program. I consent to the administration of the vaccine(s) requested. I authorize the information to be forwarded to my physician, the authorizing physician, State Immunization Information System, or the local Dept. of Health, if applicable. **I agree to stay in the area for 15-30 minutes** after receiving my vaccination in case any immediate reactions occur. If I experience any adverse events, I consent to the administration of emergency measures deemed necessary, including administering epinephrine. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); the subsidiaries and affiliates of the pharmacy; the respective directors, officers, employees, and agents of the pharmacy 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.

Patient Signature: _____

(Parent or Guardian, if minor)

Date: _____

Vaccines Provided Today:

☐ Influenza Trivalent

☐ Influenza Adjuvanted (65+)

☐ Influenza (65+)

☐ Influenza Recombinant (FluBlok)

☐ COVID-19 Vaccine

☐ Influenza Cell-Based (Flucelvax)

☐ LAIV (FluMist)

☐ Hepatitis A

☐ Hepatitis B

☐ Hepatitis A/B (Twinrix)

☐ HPV-9

☐ RSV

☐ Pneumococcal PCV20

☐ Men ACWY

☐ Men B

☐ Shingles

☐ Tdap

☐ Other: _____

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Apply vaccine label here vaccine, lot, exp date, manufacturer, dose (ml) Route Admin. Date Right or Left Arm Admin. Site VIS Date (on form) Administrator*	Apply vaccine label here vaccine, lot, exp date, manufacturer, dose (ml) Route Admin. Date Right or Left Arm Admin. Site VIS Date (on form) Administrator*
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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 the vaccine