Vaccine Informed Consent Form

Patient Name: _____**Date of Birth**: _____/_____/_____

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

Gender: ☐ Female ☐ Male **Home Phone**: _____**Cell Phone**: _____

Physician Name: _____**City**:_____

I want to receive the following immunization(s):

☐ Flu (Influenza) ☐ High Dose Flu (ages 65+) ☐ Pneumonia (pneumococcal) ☐ Shingles (Shingrix)

☐ Tdap (tetanus, diphtheria, pertussis) ☐ Td (tetanus, diphtheria) ☐ MMR

☐ Hepatitis A ☐ Hepatitis B ☐ Meningococcal ACYW ☐ Meningococcal B

The following questions will help us determine if you should receive a vaccine today. Please answer these questions by checking the boxes. If a question is not clear, please ask.

For All Vaccines:	**Yes**	**No**	**Don't Know**
1. Are you sick today?			
2. Have you had any of the following symptoms in the past 14 days: Cough, fatigue, fever (temp>100.4F), muscle pain, unexpected shortness of breath, chills or sore throat?			
3. Have you been in contact with anyone with confirmed or suspected Coronavirus (COVID-19) infection within the past 14 days?			

*****If you answered yes to any of the above questions (1-3), please speak with pharmacy staff before completing the rest of this form*****

4. Do you have allergies to medications, food, a vaccine component, or latex?			
5. Have you ever had a serious reaction after receiving a vaccination?			
6. Have you had a seizure, Guillain-Barre syndrome, brain or other nervous system problem?			
7. For women: Are you pregnant or is there a chance you could become pregnant during the next month?			

For MMR only:

8. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
9. In the past 3 months, have you taken medications that weaken your immune system such as, cortisone, prednisone, other steroids, anticancer drugs, or have you had radiation treatment?			
10. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
11. Have you received any vaccinations in the past 4 weeks?			
a. If yes, please list:			

I agree that Big Y Pharmacy will notify my physician of vaccine received.
If applicable, I give Big Y Pharmacy permission to bill Medicare Part B on my behalf for vaccine.
RISKS AND POSSIBLE SIDE EFFECTS –Any vaccine may cause some side effects. The most commonly reported side effects may include soreness at the injection site and, with the flu vaccine, "mild" flu-like symptoms. Rare side effects may include allergic reaction and Guillain-Barre syndrome. If you experience unusual or severe symptoms after receiving any vaccination please contact your health care provider immediately.
I have received and read the vaccine information statement for vaccine(s) administered and explanations of possible adverse effects for the vaccinations and have had the opportunity to ask questions. I understand the benefits and risks of the vaccine and I consent to the administration of the vaccine. I acknowledge that I have been advised to remain near the vaccination location for approximately 20 minutes after administration for observation by the administering health care professional. Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators, and assignees, Big Y Foods, Inc. and their employees, owners, and representatives from any and all claims, demands, actions, and causes of action, which may result from participation in this program. I will communicate the information provided to me today about my vaccination to my primary care provider if I have one.

Signature _____ Date _____/_____/_____

(Place Store Stamp Here)

Notification of Vaccine Administered / Patient Record

Attn: _____Fax:_____
(Provider)

Patient Name: _____ DOB: _____/_____/_____

Was seen on _____/_____/_____, at a Big Y Pharmacy and received the following vaccination(s) at that time:

Vaccine Administered	Route	Dosage	Lot #	Expiration Date	Injection Site	VIS Published Date
Influenza (Quadrivalent)	IM	0.5ml			Deltoid: Left / Right	8/15/2019
Influenza (High Dose)	IM	0.5ml			Deltoid: Left / Right	8/15/2019
Influenza (Intradermal)	IM	0.1ml			Deltoid: Left / Right	8/15/2019
Prevnar 13	IM	0.5ml			Deltoid: Left / Right	10/30/2019
Pneumovax 23	IM	0.5ml			Deltoid: Left / Right	10/30/2019
Shingrix (Recombinant Zoster)	IM	0.5ml			Deltoid: Left / Right	10/30/2019
Td (tetanus and diptheria)	IM	0.5ml			Deltoid: Left / Right	4/1/2020
Tdap (tetanus, diptheria and pertussis)	IM	0.5ml			Deltoid: Left / Right	4/1/2020
Hepatitis A (Havrix)	IM	1 ml			Deltoid: Left / Right	7/20/2016
Hepatitis B (Engerix-B)	IM	1 ml			Deltoid: Left / Right	8/15/2019
Meningococcal ACWY (Menveo, Menactra)	IM	0.5ml			Deltoid: Left / Right	8/15/2019
Meningococcal B (Bexsero, Trumenba)	IM	0.5ml			Deltoid: Left / Right	8/15/2019
MMR	SC	0.5ml			Outer Arm: Left / Right	8/15/2019

Immunizer: _____ ,RPh Admin Date: _____/_____/_____