VACCINE INFORMED CONSENT FORM | WILMONT PHARMACY

PATIENT INFORMATION

Full Name (First MI Last): _____ Date of Birth: _____ Age: _____

Email: _____ Phone: _____ Gender: ☐ Male ☐ Female

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

Primary Care Doctor: _____ City/State: _____

Vaccine(s) to receive: ☐ Flu Shot ☐ Flu Mist (2-49 yrs) ☐ COVID-19 ☐ Pneumonia ☐ Shingles ☐ Other: _____

If you have a had a dose of COVID-19 previously, date of last dose: _____

	YES	NO	Don't Know or N/A
Do you feel sick today?			
Have you had COVID-19 within the last three months?			
Have you received any immunizations in the past 4 weeks? Please specify: _____			
Do you have an allergy to any food, medication or vaccine? If so, please specify allergy: _____			
Have you ever had a serious reaction or fainted after receiving any vaccination?			
Do you carry an EpiPen?			
Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?			
Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?			
In the past 3 months, have you taken medications that affect immune system such as prednisone, other steroids, or anticancer drugs, drugs for autoimmune disease (RA, Crohn's, etc.) or had radiation?			
Do you have a bleeding disorder or take a blood thinner?			
Have you ever had a seizure disorder, brain disorder, or Guillain-Barre Syndrome?			
Do you have cancer, leukemia, HIV/AIDS, history of a transplant, or an autoimmune disorder?			
Do you have a history of myocarditis or pericarditis?			
Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?			
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?			
Do you have a long-term health problem with heart, lung, kidney, diabetes, asthma, no spleen, cochlear implant, anemia or a blood/bleeding disorder? If yes, please specify: _____			
FOR WOMEN: Are you pregnant or are you planning on becoming pregnant during the next month?			
FOR CHILDREN AGES 2-4: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
FOR CHILDREN/TEENS: Has the child, sibling, or parent had a seizure; has the child had brain or other nervous system problems?			
FOR THOSE 50+: Have you had a shingles vaccination or been diagnosed with shingles in last 12 months?			
FOR THOSE 65+: Have you ever had a pneumococcal vaccination?			

INSURANCE INFORMATION

☐ I hereby authorize the pharmacy to bill my insurance on my behalf for the vaccine, administration fee, & receive payment.
Member #: _____ PCN #: _____ BIN #: _____

ACKNOWLEDGEMENTS

☐ I attest that the answers provided here are accurate to the best of my knowledge.

☐ I understand the benefits and risks of the vaccination(s) as described in the Vaccine Information Sheet (VIS) or Emergency Use Authorization (EUA), a copy of which I was provided with this Consent & Release. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent & Release.

☐ I have received a copy of the notice of Privacy Practices. I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the pharmacy & of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Signature of Patient to Receive Vaccine
(or Signature of Power of Attorney or Legal Guardian) _____ Date: _____

Parent/Guardian Name: _____ Relationship to patient: _____

PHARMACY USE ONLY

VACCINE	BRAND/MFG	LOT	EXP. DATE	DOSAGE	INJECTION SITE	VIS DATE	STATUS
Seasonal Influenza ☐ Quad ☐ HD ☐ Fluad ☐ Mist				☐ 0.7mL ☐ 0.5mL ☐ 0.25mL ☐ 0.2mL	R L Arm Thigh Intranasal IM		☐ Billed ☐ Iris ☐ Fax PCP ☐ Scanned
Other: _____				☐ 0.5mL ☐ 0.25mL	R L Arm Thigh IM		
Other: _____				☐ 0.5mL ☐ 0.25mL	R L Arm Thigh IM		
Other: _____				☐ 0.5mL ☐ 0.25mL	R L Arm Thigh IM		

Signature of Pharmacist who administered_____**Date Administered:**_____