Informed Consent to Receive Vaccines

Name: _____ **Date of Birth**_____ **Male/Female**

Street: _____ **City**_____ **Zip** _____

Phone: _____ **Primary Care Provider (optional):** _____

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider.	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, muscle pain fever (temp > 100.4F), unexpected shortness of breath, chills, or sore throat, loss of taste/odor?	☐	☐	☐
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, foods or any vaccine? (i.e. gelatin, eggs, latex, etc.)	☐	☐	☐
5. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
6. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☐	☐
7. For patients between the ages of 2 and 4 years: has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
8. If the patient is a baby: have you ever been told he or she has had intussusceptions?	☐	☐	☐
9. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
10. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, home infusions, weekly injections (i.e. Humira, Enbrel, or Xeljanz), or have you had radiation treatments?	☐	☐	☐
11. Have you, a sibling, or parent had a seizure or a brain or other nervous system problem? (i.e. Guillain-Barre Syndrome, encephalopathy)	☐	☐	☐
12. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
13. For women: Are you pregnant or is there a chance you could become pregnant in the next month?	☐	☐	☐
14. Have you received any vaccinations or skin tests in the past 4 weeks?	☐	☐	☐
15. Are you currently on anticoagulant/antiplatelet medications? (Warfarin, aspirin, Plavix, Lovenox, etc.)	☐	☐	☐
16. Are you current on all your vaccinations? (Pneumonia, Shingles, TdaP, etc.)	☐	☐	☐

I authorize the information concerning the vaccine(s) to be forwarded to my primary care physician, authorizing physician or local Dept. of Health if applicable. I further authorize the information be released to my employer for reporting purposes, if applicable. This authorization is effective for one year from the date on which it is signed. I understand I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance upon it. Hy-Vee does not require agreement with the authorization in order to provide services; however if the services are solely for the purpose of creating a medical report for a third party, those services are subject to cancellation if authorization to release the information is not provided. I understand that the person or entity that receives my information may not be covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with a covered person or entity and the medical information may no longer be protected by the regulations.

(Signature)_____I do not authorize the information be released to my employer for reporting purposes, if applicable.

(Signature)_____I do not authorize the information concerning the vaccine(s) to be forwarded to the local Dept. of Health, if applicable

I have read, or have had read to me, the Vaccine Information Statement (VIS) indicated below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s) marked above. I agree to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I hereby release Hy-Vee, its officers, employees and agents from any and all liability that might arise from this vaccination on behalf of myself, my heirs and personal representatives.

_____ _____

Patient or Guardian Signature **Date**

Authorized Pharmacist	**Admin Date**	**Vaccine**	**Vaccine Lot**	**#Exp Date**	**Manufacturer**	**VIS Date**	**Dose (mL)**

Admin Site: Right---Left –Arm---Thigh---Nasal—SQ—IM **Adverse Reaction (attach VAERS form) Notification to Primary Provider _____ (date)**