COVID-FLU CLINIC - Informed Consent for Immunization

Last Name **First Name** **Middle** **Date of Birth** **Age** **Gender**

Address **City** **State** **Zip Code** **Phone Number** ☐ **Home** ☐ **Cell**

	Screening Questions	Yes	No
1	Are you sick today?		
2	Do you have a serious allergy to ANY medications, food, pet, environmental allergens, oral medication, or latex? If yes, please list:		
3	Have you ever had a serious reaction or fainted after receiving any vaccination or injectable medication?		
4	Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine: ☐ Pfizer ☐ Moderna ☐ J&J		
5.	Do you have a seizure disorder?		
6	Do you have any medical conditions or take any medications that may weaken your immune system? If yes, please list:		
7	Are you currently taking high-dose steroid therapy (prednisone >20mg/day or equivalent) that for longer than 2 weeks?		
8	Have you received any vaccinations or skin tests in the past four to eight weeks? If yes, please list:		
9	Have you received a transfusion of blood or blood products OR been given a medication called immune (gamma) globulin in the past year?		
			Years
10	Please check all that apply to you: ☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ Tobacco Smoker ☐ 65 years or older		
11	Please indicate which vaccine(s) you would like to receive: ☐ **FLUARIX** Under 65yo ☐ **FLUZONE** High Dose 65 and older ☐ **PFIZER COVID**		

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to WhidbeyHealth Community Pharmacy and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the EUA Fact Sheet on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Centers for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the applicable Provider: (a) the disclosure of my vaccination information by the applicable Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and, to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies, State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws or federal law may permit certain disclosures of my vaccination information to or through the State HIE or to Government Agencies as required or permitted by law. I further authorize the applicable Provider to: (a) release my medical or other information, including any communicable disease (including HIV) and mental health information, to, or through, the State HIE or Government Agencies to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice. WhidbeyHealth or its affiliates may contact you, including by autodialed and prerecorded calls and texts, at any time, using the contact information provided in your patient record regarding health and safety matters, such as vaccine reminders.

Signature of Patient or Parent/Guardian of Minor Patient **Date**

Vaccine Name	Expiration Date	Manufacturer	Dose (ml)	Lot #	Dose #	Route	Site *Circle*	VIS/EAU Publication Date
							R / L Deltoid	
							R / L Deltoid	
							R / L Deltoid	

Y / N Accepted / Declined

Name of Administrator **Administration Date** **NPP Offered** **RPh Counseling**

RPh Signature [Indicates (1) VIS/EUA Provided (2) Counseling Offered and (3) Patient Eligibility Verified]

Substitution Permitted **Dispense as Written**