VACCINATION ADMINISTRATION CONSENT FORM

SECTION 1 – INFORMATION ABOUT THE PERSON RECEIVING THE VACCINE

Name: _____ Date of Birth: _____ / _____ / _____ Phone: (_____)_____

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

Gender: Male Female Other

SECTION 2 – QUESTIONS TO DETERMINE VACCINE ELIGIBILITY (circle YES or NO)

1. Are you sick today?	YES	NO
2. Do you have any long-term health conditions? *(ex: heart disease, diabetes, asthma, COPD, kidney disease, anemia)*	YES	NO
3. Do you have allergies to medications, foods, or latex? *(ex: egg, bovine, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast)*	YES	NO
4. Have you had any serious reactions from a vaccine?	YES	NO
5. Are you taking biological injectables, steroids, anticancer drugs, antivirals, or have you had recent radiation treatments?	YES	NO
6. Do you have a seizure disorder, brain disorder, Guillain-Barre Syndrome, or nervous system disorder?	YES	NO
7. Do you have a problem with your immune system, history of AIDS, bone marrow disease or tuberculosis?	YES	NO
8. During the past year, have you received blood or blood products or been given immune (gamma) globulin?	YES	NO
9. Have you had any vaccinations in the past 4 weeks?	YES	NO
10. Are you age 65 years or older? Age:	YES	NO
11. **FOR WOMEN:** Are you pregnant, or is there a chance you could become pregnant in the next month?	YES	NO

SECTION 3 – PLEASE READ CAREFULLY AND ACKNOWLEDGE WHERE APPROPRIATE

I hereby give my consent to the Sutherlin Drug Pharmacy to administer the vaccine(s) (the "Services") I have requested below.
With my initials, I certify that:

_____ I am: (i) the Patient and at least 18 years of age; (ii) the parent or guardian of the minor Patient; or (iii) the legal guardian of the Patient; or (iv) a person authorized under the law of another state or a court order to consent for the child; OR

_____ The persons identified under (ii), (iii), or (iv), in the preceding sentence are unavailable and I have authority to consent to the immunization of the child because I am a (i) grandparent; (ii) adult brother or sister; (iii) adult aunt or uncle; (iv) stepparent; or (v) another adult who has actual care, control, and possession of the child and has written authorization to consent for the child from a parent, managing conservator, guardian, or other person who, under the law of another state or a court order, may consent for the child; additionally, I certify that I do not have knowledge of any express refusals or withdrawn authorizations of consent and have not been told not to give consent for the child.

I understand that any Protected Health Information ("PHI") I provide Sutherlin Drug Pharmacy will only be used or disclosed by Sutherlin Drug Pharmacy in accordance with Sutherlin Drug Pharmacy's Health Insurance Portability and Accountability Act ("HIPAA") Notice of Privacy Practices. By signing below, I acknowledge receipt of such HIPAA Notices of Privacy Practices and consent to the uses and disclosures of PHI described therein. While Sutherlin Drug Pharmacy reserves the right to not do so, I consent to Sutherlin Drug Pharmacy reporting my immunization information to the State Immunization Registry. Should Sutherlin Drug Pharmacy elect to report my immunization history to the Alert II immunization registry, I further understand that my immunization information may be accessed by other health care providers, educators, public health representatives, state agencies and certain insurance payers. I further authorize Sutherlin Drug Pharmacy to (1) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment or otherwise, (2) submit a claim to my insurer for the below requested items and services, and (3) request payment of authorized benefits be made on my behalf to Sutherlin Drug Pharmacy with respect to the below requested items and services. I further agree to be fully financially responsible for any co-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 Sutherlin Drug Pharmacy invoices me after the time of service, upon receipt of such invoice.

NOT A SUBSTITUTE FOR A PHYSICIAN

I understand that Sutherlin Drug Pharmacy representatives are not physicians trained to diagnose and treat medical problems. I acknowledge that the administration of Services does not constitute, and should not be interpreted as, medical advice or opinions substituting for the advice of a physician. I understand that the administration of Services does not create a doctor-patient relationship between myself and Sutherlin Drug Pharmacy. I agree to consult a physician if I require medical advice or services at any time.

RELEASE, INDEMNITY AND DISCLAIMER

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 below vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements 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. I additionally acknowledge that I have received a copy of the McCoy's Pharmacy notice of privacy.

On behalf of myself, my heirs and personal representatives, I further hereby WAIVE, RELEASE, and AGREE TO INDEMNIFY, DEFEND AND HOLD HARMLESS (including for costs and attorney's fees) Sutherlin Drug Pharmacy, its staff, agents, employees and corporate affiliates 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 Services listed below, even should such damages or losses result from Sutherlin Drug Pharmacy's negligence.

Patient Signature: _____ **Date:** _____
(Parent or Legal Guardian, if minor)

Vaccine	Brand Name	Amount Administered	Manufacturer	Route	Lot Number	Site of Administration*	
Inactivated Influenza	Flublok	0.5 ml	Protein Sciences	IM		RD	LD
Inactivated Influenza	Fluzone HD	0.5 ml	Sanofi Pasteur	IM		RD	LD
Inactivated Influenza	Fluzone Quad	0.5 ml	Sanofi Pasteur	IM		RD	LD
Inactivated Influenza	Fluarix Quad	0.5 ml	GSK	IM		RD	LD
Inactivated Influenza	Flucelvax Quad	0.5 ml	Seqirus	IM		RD	LD
Inactivated Influenza	Fluvirin	0.5 ml	Seqirus	IM		RD	LD
Hepatitis A	Havrix	0.5 ml / 1 ml	GSK	IM		RD	LD
Hepatitis B	Engerix	0.5 ml / 1 ml	GSK	IM		RD	LD
Hepatitis A/B	Twinrix	1 ml	GSK	IM		RD	LD
Herpes Zoster (shingles)	Zostavax	0.65 ml	Merck	SC		RA	LA
HPV-9	Gardasil 9	0.5 ml	Merck	IM		RD	LD
Meningococcal (ACWY)	Menveo	0.5 ml	GSK	IM		RD	LD
Measles/Mumps/Rubella	MMR II	0.5 ml	Merck	SC		RA	LA
Pneumococcal-23	Pneumovax 23	0.5 ml	Merck	IM / SC		RD/RA	LD/LA
Pneumococcal-13	Prevnar 13	0.5 ml	Pfizer	IM		RD	LD
Td (tetanus/diphtheria)	Tenivac	0.5 ml	Sanofi Pasteur	IM		RD	LD
Td (tetanus/diphtheria)	Tet/Dip	0.5 ml	Grifols	IM		RD	LD
Tdap (tet/dip/pertussis)	Boostrix	0.5 ml	GSK	IM		RD	LD
Typhoid	Typhim	0.5 ml	Sanofi Pasteur	IM		RD	LD
Typhoid	Vivotif	4 caps	PaxVax	Oral		By Mouth	
Varicella (chicken pox)	Varivax	0.5 ml	Merck	SC		RA	LA
Other							

* RD - Right Deltoid, LD - Left Deltoid, RA - Right Arm, LA - Left Arm

VACCINE INFORMATION SHEET (VIS) DATES

DTaP (04/01/2020)	Hepatitis A (7/28/2020)
Hepatitis B (08/15/2019)	Hib (*Haemophilus Influenzae* type b) (10/30/2019)
HPV – Gardasil-9 (10/30/2019)	Influenza – Live, Intranasal (8/15/2019)
Influenza – Inactivated (8/15/2019)	Measles/Mumps/Rubella (MMR) (8/15/2019)
Measles/Mumps/Rubella & Varicella (MMRV) (8/15/2019)	Meningococcal ACWY (8/15/2019)
Serogroup B Meningococcal (MenB) (8/15/2019)	Pneumococcal Conjugate (PCV13) (10/30/2019)
Pneumococcal Polysaccharide (PPSV23) (10/30/2019)	Polio (10/30/2019)
Rotavirus (10/30/2019)	Tdap (Tetanus, Diphtheria, Pertussis) (04/01/2020)
Td (Tetanus, Diphtheria) (04/01/2020)	Varicella (Chickenpox) (08/15/2019)
ZOSTAVAX Zoster / Shingles (Live) (10/30/2019)	**SHINGREX** Zoster / Shingles (Recombinant) (10/30/2019)

PHARMACIST INTIALS: _____ SIGNATURE:_____

DATE OF IMMUNIZATION: _____ DATE VIS PROVIDED: _____

COVID CHECKLIST:

Any COVID contact? Y N

Any COVID symptoms? Y N

Any recent travel? Y N

Patient Temperature: _____

Immunization area sanitized before and after ☐