Richfield Community Pharmacy
440 South Main Street, Suite B
Richfield, Utah 84701
(435) 893-6808

Informed Consent for Vaccination

____
Last Name First Name MI Gender

____
Address City State Zip Code

____
Phone Number Medicare # Date of Birth Age Weight (if under 18)

____
Primary Care Provider Provider Phone Emergency Contact Phone Number

Please answer the following questions to determine if you are eligible to receive vaccination today:

1. Which vaccines are you requesting today?
___ Influenza ___ Pneumonia ___ Shingles ___ Tdap ___ Other: ____

	YES	NO
1. Do you feel sick today?	___	___
2. Do you have allergies to medication, food, or vaccine? (Examples: eggs, gelatin, gentamicin, polymyxin, neomycin, latex, phenol, or thiomersol) If yes, please list the allergies: ________________________________	___	___
3. Have you received any vaccination or skin tests in the past four weeks? If yes, please list: ___________________________	___	___
4. Have you ever had a serious reaction to any vaccine in the past?	___	___
5. Have you ever had a seizure disorder for which you are on seizure medication, a brain disorder, Guillain-Barre Syndrome, or other nervous system problem?	___	___
6. Are you 65 years of age or older?	___	___
7. Do you smoke?	___	___
8. Do you have a chronic condition or long-term health problem? (Examples: anemia, asthma, diabetes, heart disease, liver disease, lung disease) If yes, please list: ____	___	___
9. If you answered yes to question 7, 8, or 9, have you ever had a pneumonia vaccine?	___	___
10. For women: Are you pregnant or considering becoming pregnant in the next month?	___	___
11. Are you currently on home infusions, weekly injections, steroid therapy, anticancer drugs, or radiation treatments?	___	___
12. Do you have cancer, leukemia, lymphoma, HIV/AIDS, or any other immune system disorder or are you in contact with anyone who has a severely weakened immune system?	___	___
13. Have you received a transfusion of blood or blood products, or have you been given immune (gamma) globulin in the past year?	___	___
14. Do you have a nasal condition serious enough to make breathing difficult, such as a severely stuffed nose?	___	___

I certify that I am: (i) the patient and at least 18 years of age; (ii) the parent or legal guardian of the minor patient; or (iii) the legal guardian of the patient. Further, I hereby give my consent to the Richfield Community Pharmacy pharmacist, or intern under direct supervision of the pharmacist, to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the above 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 understand that it is not possible to predict all possible side effects or complications associated with receiving the vaccine(s). Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering provider. On behalf of myself, my heirs, and my personal representatives, I hereby release and hold harmless Richfield Community Pharmacy, its staff, agents, and employees from any and all liabilities or claims whether know or unknow arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that I understand the purpose/benefits of my state's immunization registry and that, depending upon my state law, Richfield Community Pharmacy may disclose my immunization information to the state immunization registry. I authorize Richfield Community Pharmacy to (i) release my medical or other information to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to facilitate care or payment (2) submit a claim to my insurer for the above requested items and services, and (3) request payment of authorized benefits be made on my behalf to Richfield Community Pharmacy with respect to the above requested items and services. I further agree to be fully financially responsible for any due 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 Richfield Community Pharmacy invoiced me after the time of service, upon receipt of such invoice.

Patient/Legal Representative Signature: ______________________________________ Date: ____________

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Protocol Prescription

___ Fluad Trivalent and administration
___ Inactivated influenza (HD) Trivalent and administration
___ Inactivated influenza vaccine (IIV3) and administration
___ Inactivated influenza vaccine (IIV4) and administration
___ Flublok (RIV4)
Sig: Inject 0.5ml intramuscularly as directed
Qty: 1 dose (0.5ml) ICD10: Z23

___ Intranasal influenza vaccine and administration
Sig: Instill one spray into each nostril as directed
Qty: 1 dose (0.2ml) ICD10: Z23

___ Tdap vaccine (Adacel, Boostrix, etc.) and administration
Sig: Inject 0.5ml intramuscularly as directed
Qty: 1 dose (0.5ml) ICD10: Z23

___ Hepatitis A vaccine (Havrix, Vaqta, etc.) and administration
Sig: Inject 1ml intramuscularly as directed
Qty: 1 dose (1ml) ICD10: Z23

___ Hepatitis B vaccine – Adult (Engerix-B, etc.) and administration
Sig: Inject 1ml intramuscularly as directed
Qty: 1 dose (1ml) ICD10: Z23

___ PPSV23 Pneumococcal vaccine (Pneumovax) and administration
___ PCV-13 Pneumococcal vaccine (Prevnar 13) and administration
Sig: Inject 0.5ml intramuscularly as directed
Qty: 1 dose (0.5ml) ICD10: Z23

___ Herpes Zoster vaccine (Zostavax) and administration
Sig: Inject 0.65ml subcutaneously as directed
Qty: 1 dose (0.65ml) ICD10: Z23

___ Herpes Zoster vaccine (Shingrix) and administration
Sig: Inject 0.5ml intramuscularly as directed
Qty: 1 dose (0.5ml) ICD10: Z23
___ First Dose ___ Second Dose

___ Other: ____
Sig: ____
Qty: _______________ ICD10: Z23

____
Pharmacist Signature Date

____Brook Rogers________________________MR2744705_____
Physician/Practitioner NPI

_440 South Main Street Richfield, Utah 84701________________(435) 893-6800______________________
Physician/Practitioner Address Phone Number

Vaccine		Lot #	Exp. Date	Manufacturer	Dosage	RTE	Site	Name/Title of Administering Pharmacist
Influenza	___IIV3 ___Influenza HD ___IIV4 ___Fluad ___Flublok (RIV4)				0.5ml	IM	L / R Deltoid	
Pneumonia	___PPSV23 ___PCV13				0.5ml	IM	L / R Deltoid	Name/Title of Intern (if applicable)
Herpes Zoster (Zostavax)					0.65ml	SC	L / R Arm	Administration Date: _______________ Date Reported to PCP _______________ Date Reported to CCP _______________
Herpes Zoster (Shingrix) ___1st Dose ___2nd Dose					0.5ml	IM	L / R Deltoid	
Tdap					0.5ml	IM	L / R Deltoid	
Other:								

Insurance Information: BIN:__________ PCN:____________ ID:_____________________ Group:___________