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

Informed Consent for Vaccination

(for patient to complete)

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 ___ COVID-19 ___ 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, polyethylene glycol, polysorbate, 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. For women: Are you pregnant or considering becoming pregnant in the next month?	___	___
7. Are you currently on home infusions, weekly injections, steroid therapy, anticancer drugs, or radiation treatments?	___	___
8. 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?	___	___
9. Have you received a transfusion of blood or blood products, or have you been given immune (gamma) globulin in the past year?	___	___
10. Do you have a bleeding disorder or are you taking a blood thinner?	___	___

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.

Insurance Information: BIN:_____ PCN:_____ ID:_____ Group:_____

Patient/Legal Representative Signature: _____ Date: _____

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Protocol Prescription

(for pharmacist to complete)

___ Inactivated influenza (HD) Trivalent and administration
___ Inactivated influenza vaccine (IIV4) and administration
___ Flublok (RIV4) and administration
Sig: Inject 0.5ml intramuscularly as directed
Qty: 1 dose (0.5ml) ICD10: Z23
___ Respiratory Syncytial Virus (Arexvy) and administration
Sig: Inject 0.5ml intramuscularly as directed
Qty: 1 dose (0.5ml) ICD10: Z29.11
___ Tdap vaccine (Boostrix) 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-20 Pneumococcal vaccine (Prevnar 20) and administration
Sig: Inject 0.5ml intramuscularly as directed
Qty: 1 dose (0.5ml) ICD10: Z23
___ SARS-COV-2 Coronavirus (Pfizer) and administration
___ SARS-COV-2 Coronavirus (Moderna) and administration
___ SARS-COV-2 Coronavirus (Novavax) and administration
Sig: Inject 0.5ml intramuscularly as directed
Qty: 1 dose (0.5ml) ICD10: Z23
___ First Dose ___ Second Dose
___ Herpes Zoster vaccine (Shingrix) and administration
Sig: Inject 0.5ml intramuscularly as directed
Qty: 1 dose (0.5ml) ICD10: Z23
___ First Dose ___ Second Dose

_____

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	___Quadrivalent ___High Dose ___Fluad				0.5ml	IM	L / R Deltoid	
Pneumonia	___PPSV23 ___PCV20				0.5ml	IM	L / R Deltoid	Name/Title of Intern (if applicable)
COVID-19	___Pfizer ___Moderna ___Novavax				0.5ml	IM	L / R Deltoid	
Respiratory Syncytial Virus (Arezvy)					0.5ml	IM	L / R Deltoid	Administration Date: _____
Herpes Zoster (Shingrix) ___1st Dose ___2nd Dose					0.5ml	IM	L / R Deltoid	Date Reported to PCP _____
Tdap (Boostrix)					0.5ml	IM	L / R Deltoid	VIS / EUA Date _____
Other:								