Last Revised: 12/2020

Informed Consent for Vaccination

Section A (Patient Information) ***please print clearly***

Last Name: _____ First Name: _____ MI: _____ Gender (M/F): _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: (_____) - _____ - _____ Birth Date: _____/_____/_____ POA (Y/N): _____

Medicare #: _____ OR Insurance Name: _____ ID: _____ Group: _____

Phys Last Name: _____ Phys First Name: _____ Phone: (_____) - _____ - _____

Section B (POA Information) ***please print clearly***

Last Name: _____ First Name: _____ Phone: (_____) - _____ - _____

Section C

I certify that I am: (i) the patient and at least 18 years old (ii) the legal guardian of the patient. I hereby give my consent for O'Connell Pharmacy Pharmacist, or the intern under the direct supervision of a pharmacist to administer the vaccine(s) requested. I understand the risks and benefits associated with the vaccines and have received, read and/or had explained to me the Vaccine Information Statements. I hereby release and hold harmless O'Connell Pharmacy and its employees from any and all liabilities or claims known or unknown in any way related to administration of the vaccine. I consent to O'Connell Pharmacy reporting the vaccination information to the state's immunization registry and releasing my medical information to my healthcare professionals, Medicare, Medicaid or other 3rd party payer as necessary to facilitate payment. I further agree to be fully financially responsible for any due amounts, including copays, coinsurance, and deductibles.

Patient Signature (or legal guardian): _____ **Date:** _____

Section D ***determines patient eligibility to receive vaccination***

Temperature on day of Vaccination: _____ **COVID Screening Needed?** ☐ **YES** ☐ **NO**

Do you have allergies to latex, medication, food or vaccines? _____
☐ YES ☐ NO ☐ DON'T KNOW

Have you ever had a reaction to receiving a vaccination? _____
☐ YES ☐ NO ☐ DON'T KNOW

Do you have a seizure, or a brain or other nervous system problem? _____
☐ YES ☐ NO ☐ DON'T KNOW

Are you breastfeeding, currently pregnant or planning on becoming pregnant in the next month? _____
☐ YES ☐ NO ☐ DON'T KNOW

Have you received any vaccination in the last four weeks? _____
☐ YES ☐ NO ☐ DON'T KNOW

Do you feel sick today, including any upper respiratory issues *(Pharmacy to Ask on Day of Vaccination)*? _____
☐ **YES** ☐ **NO** ☐ **DON'T KNOW**

Have you been diagnosed with or been in contact with any communicable disease in the last 21 days? _____
☐ **YES** ☐ **NO** ☐ **DON'T KNOW**

Section E ***for pharmacy use***

Name/Title of Administering/Authorizing Pharmacist: _____ **Date:** _____

Vaccination Given	Lot #	Exp Date	Mfgr	Dose	Route	Site	VIS Given
Influenza QIV		/ /		0.5mL	IM	L R (Deltoid)	☐
Influenza QIV High Dose		/ /	Sanofi	0.7mL	IM	L R (Deltoid)	☐
Pneumovax 23		/ /	Merck	0.5mL	IM	L R (Deltoid)	☐
Prevnar 13		/ /	Pfizer	0.5mL	IM	L R (Deltoid)	☐
Shingrix		/ /	GSK	0.5mL	IM	L R (Deltoid)	☐
Boostrix Tdap		/ /	Sanofi	0.5mL	IM	L R (Deltoid)	☐

Reported to PCP Date: _____ / _____ / _____ **Recorded in WIR:** _____ / _____ / _____

This form constitutes pharmacist consent of a medication order per O'Connell Pharmacy LTD Vaccination Protocol