Immunization Consent Form

PATIENT'S LAST NAME | PATIENT'S FIRST NAME | birth date (MM/dd/yyyy) | Age

Address (street, city, state, zip) | Phone Number

Primary Care Doctor | Medicare B / Insurance ID Number | Gender | Race | Ethnicity

Screening Questions	YES	NO	Screening Questions	YES	NO
Are you feeling sick today?			Have you ever had a serious reaction after receiving a vaccination?		
Do you have allergies to medications, a vaccine component, eggs or latex? _____			Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?		
Do you have a parent, brother, or sister with an immune system problem?			In the past year, have you received a transfusion of blood/blood products, or been given immune (gamma) globulin or an antiviral drug?		
Have you received any vaccinations in the past 4 weeks?			Have a history of Guillain-Barré Syndrome (GBS)		
Have you had a seizure or a brain or other nervous system problem? if so, ☐Stable/resolved ☐Occurred within 7 days of an immunization			For women: Are you pregnant or is there a chance you could become pregnant during the next month?		
Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?					
In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?					

"I have read the adverse reactions associated with the administration of vaccines. I have received a copy of the Vaccine Information Statement(s) for the vaccine(s) administered to me today. A copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from the patient's receipt of the immunization(s) Patient medical record may be shared with my physician or other healthcare and will be recorded in the Massachusetts Immunization Information System. I am requesting that the immunization(s) be given to me or my Ward. I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives and assigns, hereby release the pharmacy, and its affiliates, subsidiaries, prescriber, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt by my Ward of this or these immunization(s). Neither the pharmacy nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. The pharmacy will use and disclose your personal and health information or the personal and health information of your Ward, to treat you or your Ward, to receive payment of the care we provide, and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. I acknowledge that I have been offered a Notice of Privacy Practices."

"I request that payment of authorized Medicare benefits be made to me or on my behalf to Whole Health Pharmacy for any services furnished me. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable for related services."

"I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. I understand my treatment may create circumstances, such as person-to-person contact, in which COVID-19 can be transmitted. I understand that I am opting for an elective treatment that may not be urgent, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being at the treatment location. I confirm I am not experiencing any of the following symptoms of COVID-19: *Fever *Dry Cough *Sore Throat *Shortness of Breath *Runny Nose *Loss of Taste or Smell.

I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. I have been offered a copy of this consent form. I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC."

Scan QR with smartphone for CDC VIS

Signature of Person to Receive Vaccine & VIS (or Signature of Parent/Guardian):

Signature: _____ **Date: _____**

ADMINISTRATION RECORD

PHARMACY USE ONLY

I.M. L R delt.

Vaccine:	Exp:
MFG:	Lot:
Dose: mL	I.M. L R delt.

ADMINISTERED BY: _____

I.M. L R delt.

☐ MIIS ☐ Scanned ☐ FMD ☐ 2nd dose future fill on /

R5