Informed Consent for Immunization Vaccine

❒ M ❒ F ❒ Other

Last Name **First Name** **Middle** **Date of Birth** **Age** **Gender**

Home Address **City** **State** **Zip** **Phone #** ( ) - ❒ Home ❒ Cell

Email: _____ **Country of Birth:** _____ **Language Spoken in Home:**_____

Race: ❒ Asian ❒ Black or African American ❒ Hispanic ❒ American Indian ❒ Caucasian ❒ Pacific Islander ❒ Two or More ❒ Other: _____
Ethnicity: ❒ Hispanic or Latino ❒ Non-Hispanic or Latino ❒ Decline to State (Unknown)

Vaccine(s) requested: ❒ Flu ❒ COVID-19 ❒ Pneumonia ❒ Shingles ❒ Tetanus ❒ Other: (Please Specify) _____

Which arm do you prefer for vaccine? (Please circle) **Left** **Right** **Weight in pounds:** _____**Lbs.** **Primary Care Provider Name/No#:** _____

Screening Questions – NOTE: If you answered yes to any questions below, you should talk to your healthcare provider about vaccir		**Yes**	**No**	
1.	Are you sick today?	❒	❒	
2.	Do you have a serious allergy to ANY medications, food, pet, environmental allergens, oral medication or latex? (e.g. eggs, gelatin, thimerosal) If yes, please list: _____	❒	❒	
3.	Have you ever had a serious reaction or fainted after receiving any vaccination or injectable medication?	❒	❒	
4.	Have you ever received a dose of COVID -19 vaccine or passive antibody monoclonal therapy treatment within the last 90 days? If yes, which product did you receive? ❒ Pfizer ❒Moderna ❒ J&J Date: _____	❒	❒	
5.	Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem? (Tdap & pertussis)	❒	❒	
6.	Do you have a parent, brother, or sister with an immune system problem?	❒	❒	
7.	Do you have a medical condition or take medication(s) that may weaken your immune system? If yes, please list: _____	❒	❒	
8.	For women: Are you pregnant or are you considering becoming pregnant in the next month?	❒	❒	
Immunization Questions		**Yes**	**No**	**Unsure**
9.	Please check all that apply to you: ❒ Asthma ❒ Diabetes ❒ Heart Disease ❒ Tobacco Smoker ❒ 65 Years or older. - If you checked any of the above, have you ever received a PNEUMONIA vaccine? If yes, when? _____	❒	❒	❒
10.	Patients 50 and older: Have you ever received the SHINGLES vaccine?	❒	❒	❒
11.	How many years has it been since your last TETANUS vaccine?	_____ yrs		❒
12.	Patients 45 and under: Have you received the HPV (Human Papillomavirus) vaccine?	❒	❒	❒
13.	Have you received a meningitis vaccine?	❒	❒	❒
14.	Please indicate which vaccine(s) you would like more information about? ❒ COVID-19 ❒ Hepatitis B ❒ Pneumococcal ❒ HPV ❒ Other: _____			

Informed Consent: Please read and sign.

By my signature below, I consent to the administration of the vaccine(s) by a healthcare provider or other authorized person, where permitted by law or state/federal guidance, employed or contracted by PBJ Medical Associates, LLC Companies or one of its affiliated and to be contacted at the number provided above regarding other immunizations for which I am due or eligible to receive. The above information is true and correct. I attest I meet eligibility criteria for the vaccination (if any); if I am the parent/guardian of the minor patient, I attest the minor patient meets eligibility criteria for the vaccination. I also release PBJ Medical Associates, LLC and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting, or arising from my receipt or the receipt of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination and understand that I am obligated to pay for all products and services received, if applicable. 2) I am responsible for payments on or before the date of service. 3) I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient. 4) I will immediately alert the healthcare provider of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine. 5) I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects. 6) I should remain in the area for observation for 15 minutes unless I have a history of an immediate allergic reaction of any severity to a vaccine or injectable therapy or if I have a history of anaphylaxis due to any cause I should remain in the area for observation for 30 minutes after the vaccination. If I leave the area without waiting, I acknowledge that I am doing so at my own risk and against the advice of the professional who administered the vaccine. 7) I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization ("EUA") provided for the vaccine(s) to be administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). 8) I have been offered and/or provided a copy of the company's Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA). 9) This vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting by PBJ Medical Associates, LLC or its business associate to an immunization registry, which may share my immunization data with others, and to my primary care physician, the authorizing physician, or the local Department of Health, if applicable, and I authorize these disclosures.

X

Signature of Patient or Parent/Guardian of Minor Patient **Date**

For Healthcare Professional Use Only

Vaccine Name	**Lot #**	**Expiration Date**	**Manufacturer**	**Dose (ml)**	**Dose #**	**Route**	**Site** (circle)	**VIS/EUA Publication Date**
							R / L Deltoid	
							R / L Deltoid	
							R / L Deltoid	

Name of Administrator: _____ **Administration Date**: _____ ❒ **NPP Offered** **Counseling (Please circle):** Accepted / Declined
Signature [Indicates (1) VIS/EUA Provided (2) Counseling Offered and (3) Patient Eligibility Verified]: _____

Complete DURING the patient interaction

1. I have asked the patient to confirm their **Name, DOB and Requested Vaccine** and verified it matches the information on the form. Initial here:

2. I have reviewed the VIS/EUA Patient Fact Sheet with the patient. Initial here:

3. For COVID-19, Shingrix®, MMR® II, Varivax®, YF-Vax®, Menveo®, Imovax®, Vaxchora® and RabAvert®, ensure the vaccine is reconstituted following the package insert's instructions. Initial here: