Informed Consent for Immunization Vaccine

9. Please check all that apply to you: Asthma Diabetes Heart Disease Tobacco Smoker 65 Years or older. 1f you checked any of the above, have you ever received a PNEUMONIA vaccine? If yes, when?	Last Nam	e		First Name	Middle			Date of Birth	, ,	Age		Gend	er
Race: Asian Black or African American Hispanic American Indian Caucasian Pacific Islander Two or More Other: Inthicity: Hispanic or tatino Non-Hispanic or tatino Decline to State (Unknown) Incacine(s) requested: Hispanic or James Hispanic Tanana Shingles Teanus Other: Please certo(s) Incardio Teanus Other: Please certo(s) Incardio Teanus Other: Please series Please Incardio Teanus Other: Please Please Incardio Teanus Other: Please Please Incardio Teanus Teanus Other: Please Please Incardio Teanus Teanus Other: Please Teanus	Home Ad	dress		City	Stat	e		Zip	Phone #	J Home	☐ Ce	ll .	
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Ankich arm do you prefer for vaccine? Neight in pounds:	Ethnicity	: 🗖 Hispanic o	or Latino 🗖 Non-	Hispanic or Latino	Decline to State	(Unknown)							
Please circle) Left Right Creening Questions – NOTE: If you answered yes to any questions below, you should talk to your healthcare provider about vaccir 1. Are you sick today? 2. Do you have a serious allergy to ANY medications, food, pet, environmental allergens, oral medication or latex? (e.e. eggs, peten. 3. Have you ever had a serious reaction or fainted after receiving any vaccination or injectable medication? 4. Have you ever head a serious reaction or fainted after receiving any vaccination or injectable medication? 5. Have you ever head a serious dose of COVID-19 vaccine or passive antibody monoclonal therapy treatment within the last 90 days? If yes, which product did you receive? 5. Have you ever head a serious feathing the product did you receive? 6. De you have a parent, briefly official for the product official for the product did you receive? 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? 9. Please check all that apply to you: Asthma Diabetes Heart Disease Tobacco Smoker 65 Years or older. 11. How many years has it been since your last TETANUS vaccine? 12. Patients 59 and older. Have you ever exceived a PNEUMONIA vaccine? If yes, when? 13. Have you received a membrings vaccine? 14. Device the deal of the above, have you ever received a PNEUMONIA vaccine? If yes, when? 14. Patients 45 and under: Have you received the HPV (Human Papillomovirus) vaccine? 14. Patients 45 and under: Have you received the HPV (Human Papillomovirus) vaccine? 14. Please indicate which vaccine(s) you would like more information about? 14. Power of the provided of the provided and to be contacted with the manuer provider or other ambroard person, where permitted by law or catar/fideral guidance, employed or contracted by PNI Medical Associates. It compares or one of its fillies on the vaccine(s) has been information to the min	Vaccine(s	s) requested:	☐ Flu ☐ COVID-	-19 🔟 Pneumonia	☐ Shingles ☐ 1	letanus L	Other: (Ple	ease Specify)					
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Any 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 PBI 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. It is the most legibility criteria for the vaccination (I any); if I am the parent/guardian of the minor patient, I attest the minor patient meets legibility criteria for the vaccination. I also release PBI Medical Associates, and its subsidiaries, afficiates, 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 understa hat: 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 serv min 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 responal 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 followith my physician at my expenses if I experience any side effects. 3) 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 a true with they provided any orgonome of the company's dear do the parenty's professional who administered the vaccine. 7) I have read road to me, the calcination. Information administered the vaccine. 30 in a since the parenty of the vaccine of the vaccine of the vaccine of the vaccine of	14.												
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For Healthcare Professional Use Only Vaccine Name Lot # Expiration Date Manufacturer Dose (ml) Dose # Route Site (circle) VIS/EUA Publication R / L Deltoid R / L Deltoid R / L Deltoid	Associates, L attest I mee and its subsi that: 1) I hav am of legal a personal hea with my phy therapy or if risk and agai vaccine(s) to provided a c protections	LC Companies or or te ligibility criteria didaries, affiliates, c re voluntarily chose age and authorized alth or effectiveness sician at my expens I have a history of nst the advice of the be administered. I opy of the company under state or fede	ne of its affiliated and to for the vaccination (if a officers, directors, emp in to receive the vaccina to execute this consent to of the vaccine. 5) I have if I experience any sid anaphylaxis due to any- e professional who adm have had the opportun f's Notice of Privacy Pra ral law, is subject to rep	be contacted at the numbry); if I am the parent/guard loyees, and agents from all tion and understand that I a form or I am the parent/guare been counseled about pot le effects. 6) I should remain cause I should remain in the ninistered the vaccine. 7) I hity to ask questions, and all cities in compliance with thorting by PBJ Medical Assoc	er provided above regard ian of the minor patient, liability, including acts of mobiligated to pay for all ardian of the minor patie ential side effects after v. in the area for observation for ave read, or have had reamy questions have been a le Health Insurance Portaliates, LLC or its business	ing other immu I attest the min f omission or cc I products and s nt. 4) I will immaccination, whe on for 15 minut 30 minutes after d to me, the Va answered to my bility and Accou associate to an	nizations for whoor patient mee ommission, resi ervices receive lediately alert the they may occes unless I have in the vaccinatic ccine Informatic satisfaction. I untability Act (H	nich I am due or eligi tts eligibility criteria i ulting, or arising fro d, if applicable. 2) I a he healthcare provio ur, and when and w a a history of an imm on. If I leave the area on Statement(s) ("V understand the bene IPAA). 9) This vaccin	ible to receive. The for the vaccination mmy receipt or the responsible for the responsible for the reference is should see nediate allergic reason without waiting its of the responsibility. The responsibility is not responsible to the responsibility in the responsibility is not responsibility. The responsibility is not responsibility in the responsibility in the responsibility is not responsibility in the	ne above info on. I also rele the receipt o or payments o al conditions ex treatment eaction of any ag, I acknowle y Use Author the vaccine(s	ormation case PBJ N of this vac on or bef which ma . I am res y severity edge that rization (' i). 8) I hav on grante	is true and comedical Association. I use the date and adversely ponsible for to a vaccine. I am doing selection of the date and doing selection of the date additional association.	orrect. I ociates, LLC nderstand of service. 3) I affect my following up or injectable o at my own ded for the ed and/or privacy
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Signature [Indicates (1) VIS/EUA Provided (2) Counseling Offered and (3) Patient Eligibility Verified]:						 nt Eligibility							

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: