

IMMUNIZATION INFORMED CONSENT

<u>First Name</u>	<u>MI</u>	<u>Last Name</u>	
<u>Cell Phone</u>	<u>Date of Birth (mm/dd/yyyy)</u>	<u>Age</u>	<u>M</u> <u>F</u> <u>Gender</u>
<u>Home Address</u>	<u>City</u>	<u>State</u>	<u>Zip Code</u>
<u>Email Address</u>	<u>SS# - OR - Driver's License State and #</u>		
<input type="checkbox"/> American Indian or Alaska Native; <input type="checkbox"/> Native Hawaiian or Pacific Islander; <input type="checkbox"/> Asian; <input type="checkbox"/> Black/African American; <input type="checkbox"/> White; <input type="checkbox"/> Hispanic/Latino; <input type="checkbox"/> Other			

The following questions will help us determine your eligibility to be vaccinated today.		Yes	No	???
	1. Do you have a fever or illness today?	___	___	___
	2. Have you experienced any of the following in the past 14 days: fever, unusual cough, unusual shortness of breath?	___	___	___
	3. Have you or a household contact been diagnosed with COVID-19 in the past 14 days?	___	___	___
	4. Do you have allergies to medications, food (e.g. eggs), latex, or a vaccine component (e.g. bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol or thimerosal)? If yes, please list the allergies _____	___	___	___
	5. Have you been diagnosed with heart inflammation (myocarditis or pericarditis) in the past?	___	___	___
	6. Have you received any convalescent plasma or COVID-19 antibodies in the past 90 days?	___	___	___
	7. Have you ever had a serious reaction to any vaccine in the past?	___	___	___
	8. 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?	___	___	___
	9. Are you 65 years of age or older?	___	___	___
	10. Do you have a chronic condition or long-term health problem? If yes, please check all that apply. ___ Anemia ___ Asthma ___ Diabetes ___ Heart disease ___ Kidney disease ___ Liver disease ___ Lung disease ___ Obesity ___ Smoker	___	___	___
	11. If you answered YES to question 9 or 10, have you ever had a pneumonia vaccination?	___	___	___
	12. Have you ever had a shingles vaccination (for patients 50 years of age and older only)?	___	___	___
	13. For women: Are you pregnant or considering becoming pregnant in the next month?	___	___	___
LIVE VACCINES	14. For the past 3 months, have you taken medications that affect your immune system, such as prednisone or other steroids, anti-cancer drugs, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis; or have you had radiation treatments?	___	___	___
	15. 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?	___	___	___
	16. Have you received a transfusion of blood or blood products, or been given immune (gamma) globulin in the past year?	___	___	___
	17. Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)	___	___	___
	18. If the patient receiving vaccine is under 5 years old, is there a history of asthma or wheezing? (for FluMist® only)	___	___	___
	19. Does the patient have a nasal condition serious enough to make breathing difficult, such as a very stuffy nose? (for FluMist® only)	___	___	___

I certify I am the patient and at least 18 years of age; the legal guardian of the patient; or a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. I have received a Notice of Privacy Practice for HIPAA. I have read, or have had read to me, the Vaccine Information Statement (VIS) or EUA referred to above. I have been able to ask questions about the vaccine(s), and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to the administration of the vaccine(s) requested. I authorize the information to be forwarded to my physician, the authorizing physician, State Immunization Information System, or the local Dept. of Health, if applicable. **I agree to stay in the general area for 15-30 minutes** after receiving my vaccination in case any immediate reactions occur. If I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); the subsidiaries and affiliates of the pharmacy; the respective directors, officers, employees, and agents of the pharmacy and its subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability that might arise from this vaccination

Patient Signature: _____ Date: _____
 (Parent or Guardian, if minor)

Vaccines Provided Today:	
<input type="checkbox"/> Influenza Quadrivalent <input type="checkbox"/> Influenza Adjuvanted (65+) <input type="checkbox"/> Influenza (65+) <input type="checkbox"/> Influenza Recombinant (FluBlok) <input type="checkbox"/> COVID-19 Vaccine <input type="checkbox"/> Influenza Cell-Based (Flucelvax) <input type="checkbox"/> LAIV (FluMist) <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A/B (Twinrix) <input type="checkbox"/> HPV-9 <input type="checkbox"/> Pneumococcal PSV23 <input type="checkbox"/> Pneumococcal PCV13 <input type="checkbox"/> Men ACWY <input type="checkbox"/> Men B <input type="checkbox"/> Shingles <input type="checkbox"/> Tdap <input type="checkbox"/> Other: _____	
David G. Cope M.D. NPI 1285698241 185 S 400 East - Bountiful, UT 84010 PH:801-397-6200	Frederic Civish M.D. NPI 1124137278 3534 W 6000 South - West Valley, UT 84128 PH:801-969-6264

<div style="border: 1px dashed gray; padding: 5px; min-height: 60px;">Apply vaccine label here</div> <p>vaccine, lot, exp date, manufacturer, dose (ml)</p>	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;"><u>Route</u></td> <td style="width:50%;"><u>Right or Left Arm</u></td> </tr> <tr> <td></td> <td style="text-align:center;"><u>Admin. Site</u></td> </tr> <tr> <td><u>Admin. Date</u></td> <td><u>VIS Date (on form)</u></td> </tr> <tr> <td colspan="2" style="text-align:center;"><u>Administrator*</u></td> </tr> </table>	<u>Route</u>	<u>Right or Left Arm</u>		<u>Admin. Site</u>	<u>Admin. Date</u>	<u>VIS Date (on form)</u>	<u>Administrator*</u>	
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By signing as administrator you are confirming that contraindications and side effects have been reviewed and a current VIS was provided to the patient receiving the vaccine