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IMMUNIZATION INFORMED CONSENT

Firs	t Nar	me		Last Name		Social Security	ity Number for Medicare A/B		
						•	М		F
Cell Phone			Date of Birth	(mm/dd/yyyy)			Gender		er
Home Address City State Zi						Zip Cod	de		
Email Address Rx Insurance (Carrier & ID#)									
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							
	3.	Have you or a household contact been diagnosed with COVID-19 in the past 14 days?							
	4.	, , , , , , , , , , , , , , , , , , , ,							
-	_	polymyxin, neomycin, phenol or thimerosal)?. If yes, please list the allergies							
-	5.	Have you ever felt dizzy or fainted after receiving an imm	unization?						
	6.	6. Have you ever had a serious reaction to any vaccine in the past?							
	7.	Have you ever had a seizure disorder for which you are or condition that causes paralysis) or other nervous system (n(s), a brain disorder, Guill	lain-Barré syndrome	e (a			
	8.	Are you 65 years of age or older?							
	9.	Do you have a chronic condition or long-term health problem? If yes, please check all that apply.							
	10.	If you answered YES to question 8 or 9, have you ever had	d a pneumonia vaco	cination?					
	11.	Have you ever had a shingles vaccination (for patients 50	years of age and ol	der only)?					
	12.	Have you ever had an RSV vaccine (for patients 60 years of	of age and older on	ly)?					
	13. For women: Are you pregnant or considering becoming pregnant in the next month?								
		4. For the past 3 months, have you taken medications that affect your immune system, such as predisone or other steroids, anti-cancer drugs, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis; or have you had radiation treatments?							
ES	15.	Do you have cancer, leukemia, lymphoma, HIV/AIDS or ar a severely weakened immune system?	ny other immune sy	ystem disorder or are you i	n contact with anyo	ne who has			
LIVE VACCINE	16.	Have you received a transfusion of blood or blood produc	ts, or been given i	mmune (gamma) globulin i	in the past year?				
E V/	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)							
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 UA 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 accine(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. 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 harmacy 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 ubsidiaries 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: [Parent or Guardian, if minor]									
Vac	ine	s Provided Today:							
☐ Influenza Quadrivalent ☐ Influenza Adjuvanted (65+) ☐ Influenza (65+) ☐ Influenza Recombinant (FluBlok) ☐ COVID-19 Vaccine									
□ Influenza Cell-Based (Flucelvax) □ LAIV (FluMist) □ Hepatitis A □ Hepatitis B □ Hepatitis A/B (Twinrix) □ HPV-9 □ RSV □ Pneumococcal PSV23 □ Pneumococcal PCV20 □ Men ACWY □ Men B □ Shingles □ Tdap □ Other:									
David G. Cope M.D. NPI 1285698241 Frederic Civish M.D. NPI 1124137278									
185 S 400 East - Bountiful, UT 84010 PH:801-397-6200 3534 W 6000 South - West Valley, UT 84128 PH:801-969-6264									
Ī		Apply vaccine label here Route Admin.	Left Arm Site	Apply vaccine label	!	Route	Right or Le		
vaccine, lot, exp date, manufacturer, dose (ml) Admin. Date VIS Date (on form) vaccine, lot, exp date, manufacturer, dose (ml) Admin. Date							VIS Date (on form)		
-		Administrator*		<u> </u>		Administra	ator*		

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

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