Willow Bark Pharmacy Informed Consent for Immunization

❒M ❒F ❒Other

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

Home Address **City** **State** **Zip** **Phone #** ❒**Home** ❒**Cell**

RACE: (circle one) WHITE, BLACK or AFRICAN AMERICAN, ASIAN, AMERICAN INDIAN or ALASKAN NATIVE, NATIVE HAWAIIAN or PACIFIC ISLANDER, OTHER

ETHNICITY: (circle one) HISPANIC or LATINO NOT HISPANIC OR LATINO

PRIMARY CARE PROVIDER NAME & PHONE: _____

Screening Questionnaire: *Please answer questions by checking the boxes.*

All Vaccines		**Yes**	**No**
1.	In the last 10 days, have you or someone you have been in close contact with been diagnosed with COVID-19?	❒	❒
2.	Do you feel sick today or do you have symptoms of fever, chills, shortness of breath, body aches, loss of taste/smell?	❒	❒
3.	Do you have a serious allergy to ANY medications or food (e.g. eggs, gelatin, thimerosal, neomycin, gentamicin, etc.)? If yes, please list: _____	❒	❒
4.	Have you ever had a serious reaction or fainted after receiving any vaccination?	❒	❒
5.	Do you have sensitivity to latex (e.g. gloves or bandages)?	❒	❒
6.	For women: Are you pregnant or are you considering becoming pregnant in the next month?	❒	❒
7.	Have you received any vaccination in the past 4 weeks? If yes, please list: _____	❒	❒
8.	Do you have cancer, leukemia, HIV, active shingles or any other immune system problem?	❒	❒
9.	Do you take prednisone, oral steroids, anticancer or antiviral drugs or medications that affect the immune system?	❒	❒
10.	During the past year, have you received a transfusion of blood or blood products, been given a medicine called immune (gamma) globulin, or had radiation therapy?	❒	❒

Informed Consent: *Please read and sign.*

By my signature below, I consent to the administration of the vaccine(s) by a pharmacist employed by Willow Bark Pharmacy. I also release Willow Bark Pharmacy and its officers, directors, employees, and agents from all liability, including acts of omission or commission, result or arising from my receipt of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination. 2) I may be responsible for payment on the date of service. 3) I am of legal age and authorized to execute this consent form or I am not of legal age and have obtained the signed consent of a parent or guardian. 4) I will immediately alert the pharmacist 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. I am responsible for following up with my physician at my expense if I experience any side effects. 6) I have been advised that I should remain in the area for 15 minutes after the vaccination for observation. 7) I have read the Vaccine Information Statement(s) ("VIS") 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) This vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting to an immunization registry, which may share my immunization data with my primary care physician, if applicable, and I authorize these disclosures.

X_____>>>>>>>>>

Signature of Patient or Parent/Guardian of Minor & Date

Request of HIPAA Notice?

Yes or No

For Pharmacy Use Only

Vaccine Name	**Lot #**	**Expiration Date**	**Manufacturer**	**Dose (ml)**	**Route**	**Site** (circle)	**VIS Publication Date**
Fluarix Quad 2020-21			***GSK***	*0.5*	*IM*	*R / L Deltoid*	08-15-2019
Shingrix®			*GSK*	*0.5*	*IM*	*R / L Deltoid*	10-30-2019
Fluad Quad 2020-21			*Seqirus*	*0.5*	*IM*	*R / L Deltoid*	08-15-2019
Moderna COVID-19 Vaccine			*ModernaTx,Inc*	*0.5*	*IM*	*R / L Deltoid*	Fact Sheet 12/2020

Pharmacist's Signature:_____ **Date VIS/FACT SHEET Given:**_____

Administration Date:_____ **Body Temperature:**_____