

UTAH INFORMED CONSENT TO RECEIVE VACCINES

Appointment or clinic date _____

Appointment time _____

First Name _____	MI _____	Last Name _____
Home Phone _____	Date of Birth (mm/dd/yyyy) _____	Age _____
Home Address _____	City _____	State _____
Insurance BIN # _____	Insurance PCN # if applicable _____	Group # if applicable _____
		Insurance ID # _____

	Yes	No	Don't Know
<i>The following questions will help us determine your eligibility to be vaccinated today.</i>			
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 received any vaccinations or skin tests in the past 28 days? If yes, please list the vaccination. _____	___	___	___
6. Have you ever had a serious reaction to an influenza vaccine or any other vaccine in the past?	___	___	___
7. 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?	___	___	___
8. Are you 65 years of age or older?	___	___	___
9. Do you smoke?	___	___	___
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 ___ Other	___	___	___
11. If you answered YES to question #6, 7 or 8, 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 a medicine called 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 have read, or have had read to me, the Vaccine Information Statement (VIS) referred to above. I have had the opportunity 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 primary care physician, the authorizing physician, Utah State Immunization Information System (USIIS), or the local Dept. of Health, if applicable. **I agree to stay in the general area for 15 minutes** after receiving my vaccination in case any immediate reactions occur. I understand that 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)

Please initial that you have received our Notice of Privacy Practice for HIPAA

Vaccines Provided Today:

Influenza Quadrivalent
 Influenza Adjuvanted (65+)
 Influenza High Dose (65+)
 Influenza Recombinant (FluBlok)
 Influenza Cell-Based (Flucelvax)
 LAIV (FluMist)
 Hepatitis A
 Hepatitis B
 Hepatitis A/B (Twinrix)
 HPV-9
 Pneumococcal PSV23
 Pneumococcal PCV13
 Men ACWY
 Men B
 Shingles
 Tdap
 Other: _____

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Vaccine Information (Office use only)

_____	_____	_____	_____	_____
Vaccine	Lot #	Exp. Date	Manufacturer	Dose (ml)
_____	<i>Right or Left Arm</i>		_____	_____
Route	Admin. Site	Admin. Date	VIS Date (on form)	
_____			_____	
Administrator*			Store # (where patient receives vaccine)	

Vaccine Information (Office use only)

_____	_____	_____	_____	_____
Vaccine	Lot #	Exp. Date	Manufacturer	Dose (ml)
_____	<i>Right or Left Arm</i>		_____	_____
Route	Admin. Site	Admin. Date	VIS Date (on form)	
_____			_____	
Administrator*			Store # (where patient receives vaccine)	

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.

ADHERE LABELS HERE