Clinic Vaccine Informed Consent Form

First Name:	Last Name:	Date of Birth:	Gender:
Street Address:	City:	State:	Zip code:
Home Phone:	Cell Phone:	Administration site (circle one): **L** arm or **R** arm	
Race/Ethnicity:			
☐ American Indian or Alaska Native	☐ Black or African American	☐ White	☐ Other
☐ Hispanic or Latino American	☐ Pacific Islander	☐ Asian	

I want to receive the following immunization(s):

☐ Flu ☐ COVID-19

☐ Flu (65+ years)

Please answer each question by checking the appropriate boxes. If a question is not clear, please ask.

This section to be completed ALL vaccines.	**Yes**	**No**	**Don't Know**
1) Are you sick today?			
2) Do you have allergies to medications, food, a vaccine component or latex?			
3) Have you ever had a serious reaction after receiving a vaccination?			
4) Have you had a seizure, Guillan-Barre syndrome, brain or other nervous system problem?			
5) For women: Are you pregnant or is there a chance you could become pregnant during the next month?			

This section to be completed for COVID Vaccine only.	**Yes**	**No**	**Don't Know**
1) Have you received a dose of COVID-19 vaccine? If so, which product? ☐ Moderna ☐ Pfizer ☐ Janssen (J&J)			
2) Have you ever had an **allergic reaction** to: • A component of a COVID-19 vaccine, including either of the following: ○ Polyethylene glycol (PEG) which is found in some medications such as laxatives, and preparations for colonoscopy procedures ○ Polysorbate, which is found in some vaccines, film coated tablets and intravenous steroids ○ Previous dose of COVID-19 vaccine			
3) Have you ever had an **allergic reaction** to another vaccine (other than COVID-19 vaccine) or another injectable medication?			

4) Check all that apply:

☐ Female between ages 18 and 49 years old	☐ Have a history of myocarditis or pericarditis	☐ Have received dermal fillers
☐ Are currently pregnant or breast feeding	☐ Have a bleeding disorder	☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
☐ Male between 12 and 29 years old	☐ Take a blood thinner	☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after COVID infection
☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies	☐ Have a history of heparin-induced thrombocytopenia	☐ Have a weakened immune system (i.e. HIV, Cancer) or take immunosuppressive drugs or therapies
	☐ History of Guillain-Barre Syndrome (GBS)	

Allergic reaction: This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)

I agree that Big Y Pharmacy will notify my physician of vaccine received via state IIS. If applicable, I give Big Y Pharmacy permission to bill Medicare Part B on my behalf for vaccine.RISKS AND POSSIBLE SIDE EFFECTS –Any vaccine may cause some side effects. The most commonly reported side effects may include soreness at the injection site and, with the flu vaccine, "mild" flu-like symptoms. Rare side effects may include allergic reaction and Guillain-Barre syndrome. If you experience unusual or severe symptoms after receiving any vaccination, please contact your health care provider immediately. I have received and read the vaccine information statement for vaccine(s) administered and explanations of possible adverse effects for the vaccinations and have had the opportunity to ask questions. I understand the benefits and risks of the vaccine and I consent to the administration of the vaccine. I acknowledge that I have been advised to remain near the vaccination location for approximately 20 minutes after administration for observation by the administering health care professional. Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators, and assignees, Big Y Foods, Inc. and their employees, owners, and representatives from any and all claims, demands, actions, and causes of action, which may result from participation in this program. I will communicate the information provided to me today about my vaccination to my primary care provider if I have one.

Patient or Parent/Legal Guardian: _____ **Date:** _____/_____/_____

If Parent/Legal Guardian, please print name and relation to patient: _____

Place store stamp here:

Insurance Info:

BIN:		**Medicare Part B**	
PCN:		**CT Medicaid**	
Cardholder ID:		**MassHealth**	
Rx Group:		**Last 4 digits SSN**	

For Pharmacy Use:

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ Date: _____

RX:

Vaccine Administered	Route	Dosage	Lot #	Expiration Date	Injection Site	VIS Date
Influenza	IM	0.5 ml			Deltoid: Left / Right	8/6/21
Influenza (65+)	IM				Deltoid: Left / Right	8/6/21
Moderna COVID-19	IM	0.5 ml			Deltoid: Left / Right	10/19/23
Pfizer COVID-19	IM	0.3 ml			Deltoid: Left / Right	10/19/23

SIG: To be administered

Prescriber: Robert Wool DEA AW1427601

ICD10: **Z23**

Immunizer: _____, RPh Admin Date: _____/_____/_____