Informed Consent for Immunization with Inactivated Vaccine

By my signature below, I consent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist or technician, or other authorized person, where permitted by law or state/federal guidance, employed or contracted by Albertsons Companies or one of its affiliated pharmacies and to be contacted at the number provided above regarding other immunizations for which I am due or eligible to receive. The above information is true and correct. I attest I meet eligibility criteria for the vaccination (if any); if I am the parent/guardian of the minor patient, I attest the minor patient meets eligibility criteria for the vaccination. I also release Albertsons Companies and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting, or arising from my receipt or the minor's receipt of this vaccination. I understand the benefits and risks of the vaccine(s). I have been offered and/or provided a copy of the company's Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA). This vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting by my pharmacy or its business associate to an Immunization registry, which may share my Immunization data with others, and to my primary care physician, the authorizing physician, or the local Department of Health, if applicable, and I authorize these disclosures.

Screening Questions – NOTE: IF COMPLETED ONLINE, REVIEW ANSWERS WITH PATIENT TO ENSURE NO CHANGES

1. Are you sick today?
2. Do you have a serious allergy to ANY medications, food, pet, environmental allergens, oral medication or latex? (e.g. eggs, gelatin, thimerosal, neomycin, gentamicin, polyethylene glycol (PEG), polycarbate etc.)? If yes, please list:
3. Have you ever had a serious reaction or fainted after receiving any vaccination or injectable medication?
4. Have you ever received a dose of COVID-19 vaccine? (COVID-19 only)
5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19 within the last 90 days? (COVID-19 only)
6. Do you have a seizure disorder or a brain disorder? (Tap only)
7. Do you have a medical condition or take medication(s) that may weaken your immune system? If yes, please list:
8. For women: Are you pregnant or are you considering becoming pregnant in the next month?
9. Please check all that apply to you: Asthma Diabetes Heart Disease Tobacco Smoker 65 Years or older.
   - If you checked any of the above, have you ever received a PNEUMONIA vaccine? If yes, when?
10. Patients 50 and older: Have you ever received the SHINGLES vaccine?
11. How many years has it been since your last TETANUS vaccine?
12. Patients 45 and under: Have you received the HPV (Human Papillomavirus) vaccine?
13. Patients aged 11 to 23: Have you received a meningitis vaccine?
14. Please indicate which vaccine(s) you would like more information about?
   - Hepatitis A
   - Hepatitis B
   - MMR (Measles, Mumps, Rubella)
   - Travel Vaccines

Informed Consent: Please read and sign.

Signature of Patient or Parent/Guardian of Minor Patient Date

For Pharmacy Use Only

Vaccine Name Lot # Expiration Date Manufacturer Dose (ml) Dose # Route Site (circle) VIS/EUA Publication Date

R / L Deltoid
R / L Deltoid
R / L Deltoid

Name of Administrator: ____________________________ Administration Date: ____________ NPP Offered: _______ RPh Counseling (Please circle): Accepted / Declined

RPh Signature [Indicates (1) VIS/EUA Provided (2) Counseling Offered and (3) Patient Eligibility Verified]: ____________________________

WA ONLY: Substitution Permitted: ______ Dispense as Written: ______

RxBIN: __________ PCN: __________ Group #: __________ ID#: __________

Medical (Name, ID#, Group#, Payer ID - if UHC): ____________________________

Billing Info (off-site only) Clinic Name: ____________________________ Clinic Address: ____________________________

Ver.1 2021