Rightway Pharmacy Informed Consent for Immunization

What vaccine will you be receiving?

1._____ 2._____ 3._____

PATIENT INFORMATION				
Patient's Last Name: **Patient's First Name:**		**Phone Number:**	**Age:**	**Birth date:**
Street Address:	**City:**		**State:**	**Zip Code:**
Ethnicity: Hispanic or Latino ____ Yes ____ No **Gender** ____ Male ____ Female	**Race:** (Select one or more.) ____AS-Asian/Pacific Islander/Other ____ IN-Native American/Alaska Native ____BL-Black or African American ____ UN-Unknown ____ NW-Other Non-White ____CA-Caucasian/Mexican/Puerto Rican		**Arm:** ___Left ___Right	
Primary Care Physician:	**Street Address:**	**State:** **Zip:**	**Phone:** **Fax:**	

PATIENT INSURANCE				
Medicare Part B ID # or Last 4 of SSN:	Rx BIN:	PCN:	Rx Group #:	ID #:

IMMUNIZATION SCREENING QUESTIONNAIRE	
1. Is the person to be vaccinated currently sick or experiencing a high fever?	___Yes ___No
2. Has the person to be vaccinated had a serious reaction to a vaccine in the past?	___Yes ___No
3. Does the person to be vaccinated have any allergies that produce a severe (anaphylactic) reaction?	___Yes ___No
4. Has the person to be vaccinated had a seizure or other neurological problem?	___Yes __No
5. Does the person to be vaccinated have any medical problems that make it hard for him/her to fight infection?	___Yes ___No
6. Does the person to be vaccinated have close, regular contact with someone with a weakened immune system?	___Yes __No
7. Is the person taking cortisone, prednisone, other steroids, or anti-cancer drugs, or had x-ray treatments?	___Yes __No
8. Has the person to be vaccinated received blood, plasma, or immune globulin in the past twelve months?	___Yes __No
9. Is the person to be vaccinated pregnant or thinking of becoming pregnant within the next three months?	___Yes __No

Informed Consent: Please read and sign.

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 Rightway Pharmacy 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. I also release Rightway Pharmacy and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting, or arising from my receipt of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination and understand that I am obligated to pay for all products and services received, if applicable. 2) I may be responsible for payment after the date of service if the product or service is billed to my medical benefit. 3) I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient. 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, when they may occur, and when and where I should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects. 6) I should remain in the area for observation for 15 minutes unless I have a history of an immediate allergic reaction of any severity to a vaccine or injectable therapy or if I have a history of anaphylaxis due to any cause I should remain in the area for observation for 30 minutes after the vaccination. If I leave the area without waiting, I acknowledge that I am doing so at my own risk and against the advice of the professional who administered the vaccine. 7) I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization ("EUA") 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) 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). 9) 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.

X _____

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
							L / R DELTOID	
							L / R DELTOID	
							L / R DELTOID	

❒ **NPP Offered RPh Counseling (Please circle): Accepted / Decline**

Name of Administrator: _____ **Administration Date:** _____

RPH Signature [INDICATES (1) VIS/EUA Provided (2) Counseling Offered and (3) Patient Eligibility Verified] _____