PUBLIX PHARMACY
Feeling well. Living better.

IMMUNIZATION CONSENT FORM

Name:_____ Birth date:___/_____/____ Age:_____ Sex: (M/F)_____

Address:_____ City: _____ State:____ Zip:_____

Phone: (____)_____ Medicare ID# (Including Alpha):_____ Publix Associates only – Personnel Number:_____

	Precautions and Contraindications: Please mark YES or NO for each question.	**YES**	**NO**
For Inactive and Live Vaccines	Do you have a cold, fever, or acute illness?		
	Do you have any allergies to medications, food, or any vaccine? **List:**_____		
	Are you allergic to chicken eggs or egg product?		
	Are you allergic to Thimerosal (cleaning products or contact lens solution)?		
	Have you ever had a serious reaction after receiving a vaccination?		
	Have you ever been diagnosed with Guillain-Barre' syndrome? *(for meningococcal)*		
	Do you have a seizure, brain, or nerve problem? *(for pertussis)*		
For Live Vaccines only	Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?		
	Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation?		
	During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?		
	For women: Are you pregnant/is there a chance you could become pregnant during the next month?		
	Have you received any vaccinations in the past 4 weeks?		
	For Intranasal Influenza: Do you have a long-term health problem such as heart, lung, kidney, liver, or metabolic disease (e.g. diabetes), neurologic or neuromuscular disease, anemia or other blood disorder?		
If you answered "YES" to any question, you must talk with your pharmacist before being vaccinated.			

ACKNOWLEDGEMENTS

I am voluntarily requesting that a pharmacist employed by Publix Super Markets, Inc. ("Publix") administer to me the following vaccines ("Vaccine"):_____.

In connection with this request, I acknowledge and attest to the following statements:

- Publix has given me a copy of the Vaccine Information Statement that contains information about the Vaccine including information on adverse reactions that I may experience as a result of receiving the Vaccine, and I have carefully read and understand the Vaccine Information Statement.
- Publix has given me a Notice of Privacy Practices that explains how Publix may use or disclose my medical information and also certain rights that I have regarding such information.
- I have had an opportunity to ask the Publix pharmacist any questions about the Vaccine or about information in the Vaccine Information Statement, including adverse reactions that I may experience as a result of receiving the Vaccine.
- I have truthfully answered all the questions regarding my medical history that are listed on the first page of this form. I understand that if I answered a question with a "Yes" there is an increased likelihood that I will experience an adverse reaction from the administration of the Vaccine. I also understand that the Publix pharmacist may decide not to administer the Vaccine to me if I answered "Yes" to some of these questions because of the risks to me associated with receiving the Vaccine.
- After careful consideration, I believe that the benefits of receiving the Vaccine outweigh the risks associated with receiving the Vaccine and I have decided to have the Publix pharmacist administer the Vaccine to me. I would elect to receive the Vaccine even if the information communicated to me by this form, or the pharmacist, were incomplete.
- If I have insurance coverage for this health care service and I want Publix to file an insurance claim on my behalf, I am responsible for providing Publix with accurate benefits information. Publix may choose not to accept an assignment of my insurance benefits and I may need to file my own insurance claim. If Publix accepts an assignment of my insurance benefits I may be responsible for any part of the unpaid claim. I am responsible for meeting any requirements for insurance coverage eligibility.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION

- If Publix files an insurance claim on my behalf for its administration of Vaccine to me then I authorize an assignment of my insurance benefits under such claim to Publix.
- I authorize Publix to use and/or disclose such information about me, including any medical related information that I provide to Publix or that is created or received by Publix that Publix reasonably determines is necessary to receive payment for its services, carry out my treatment or conduct its health care operations. This authorization includes disclosures to regulatory agencies, Medicare, Medicaid, health plans, pharmacy benefit managers, claims processors, billing companies, interpreters and other persons involved in my treatment.

WAIVER AND RELEASE OF LIABILITY

- I voluntarily agree and consent to be immunized by the Publix pharmacist. I have been adequately informed of the benefits and consequences (including adverse reactions) of the Vaccine I am about to receive. I voluntarily assume all responsibility for any adverse consequences (including, but not limited to, adverse reactions) as allowed by applicable law.
- Publix shall not, at any time, or to any extent allowable by applicable law, be liable, responsible, or in any way be accountable for any loss, injury, death, or damage suffered or sustained by me or any other person at any time in connection with, or as a result of, the administration of the Vaccine to me by the Publix pharmacist.
- I, for myself, my heirs, executors, personal representatives and assigns, hereby release Publix, its employees, specifically the administering pharmacist, its agents or representatives from any and all claims arising out of, in connection with, or in any way related to my receipt of the Vaccine from Publix as allowed by applicable law.

By signing below, I certify that the following statements are true:

- I am the patient or the patient's guardian/personal representative signing on behalf of the patient.
- I read, understand and agree to all the statements on this form.

X_____ _____ _____

Signature of Patient or Legal Guardian | Print Name of Patient | Date

For Publix Use Only:

Billing (select one)

____Medicare ____Cash ____Publix Associate ____Family Member

____Other (Specify:_____)

Vaccine Administration Record

Vaccine Type	Vaccine		Date Given (mo/day/yr)	Dose	Route (IM, SQ)	Site (RA, LA)	Vaccine Information Statement	
	Lot #	Manufacturer					Date on VIS	Date Given

Primary Care Physician Notification (Required in South Carolina)

Completed	Patient Declined
☐	☐

_____ _____ _____
Printed Name of Pharmacist Administering Vaccine | Title | Pharmacist License #

_____ _____
Pharmacy Address | City, State, Zip

_____
Pharmacy Phone #

_____ _____
Pharmacist's Signature | Drug Protocol # and Physician's Name