SHOPKO® pharmacy

Informed Consent for Vaccination

Section A Please print clearly.

LAST NAME | FIRST NAME | MI | GENDER (M/F)

ADDRESS | CITY | STATE | ZIP

( ) | MM / DD / YYYY

PHONE NUMBER | MEDICARE B # (IF APPLICABLE) | DATE OF BIRTH | AGE | IF UNDER 18, WEIGHT

PRIMARY CARE PHYSICIAN/PROVIDER NAME | PHYSICIAN/PROVIDER ADDRESS | ( ) PHYSICIAN/PROVIDER PHONE

Section B Please answer the following questions to determine if you are eligible to receive a vaccination today.

	Yes	No	Don't Know
1. Which vaccines* are you requesting to have administered today? Please check all requested vaccines. ☐ Inactivated Influenza (Flu) ☐ Pneumonia ☐ Shingles ☐ Tdap (Whooping Cough) ☐ Other: _____			
2. Do you feel sick today?	Y	N	?
3. Do you have allergies to medications, food, or vaccines? (Examples: eggs, gelatin, gentamicin, polymyxin, neomycin, phenol or thimerosal) If yes, please list the allergies: _____	Y	N	?
4. Have you received any vaccinations or skin tests in the past four weeks? If yes, please list the vaccination: _____	Y	N	?
5. Have you ever had a serious reaction to any vaccine in the past?	Y	N	?
6. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome, or other nervous system problem?	Y	N	?
7. Are you 65 years of age or older?	Y	N	?
8. Do you smoke?	Y	N	?
9. Do you have a chronic condition or long-term health problem? If yes, please check all that apply: ☐ Anemia ☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ Liver Disease ☐ Lung Disease ☐ Other:_____	Y	N	?
10. If you answered yes to question #7, 8, or 9, have you ever had a pneumonia vaccination?	Y	N	?
11. For women: Are you pregnant or considering becoming pregnant in the next month?	Y	N	?
For Live Vaccines (Shingles, Chicken Pox, Nasal Flu, etc):			
12. Are you currently on home infusions, weekly injections, steroid therapy, anticancer drugs, or radiation treatments?	Y	N	?
13. 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?	Y	N	?
14. Have you received a transfusion of blood or blood products, or have you been given a medicine called immune (gamma) globulin in the past year?	Y	N	?
15. Do you have a nasal condition serious enough to make breathing difficult, such as a very stuffy nose? (for nasal vaccines only)	Y	N	?

* Vaccines available vary by location. Check with your local pharmacy regarding current offerings.

Section C

I certify that I am: (i) the patient and at least 18 years of age; (ii) the parent or legal guardian of the minor patient; or (iii) the legal guardian of the patient. Further, I hereby give my consent to the Shopko pharmacist, or intern under the direct supervision of a pharmacist, to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Shopko, its staff, agents, and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I understand that my state may offer participation in a state immunization registry, in which case my immunization information may be supplied to the state unless I complete a state-approved opt-out process. Shopko, will, if my state permits, provide me with an opt-out form. Unless I provide Shopko with a signed opt-out form, I elect to participate fully in, and consent to Shopko reporting my immunization information to the state's immunization registry. I authorize Shopko to (1) release my medical or other information to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to facilitate care or payment, (2) submit a claim to my insurer for the above requested items and services, and (3) request payment of authorized benefits be made on my behalf to Shopko with respect to the above requested items and services. I further agree to be fully financially responsible for any due amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if Shopko invoices me after the time of service, upon receipt of such invoice.

Patient/Legal Representative Signature: _____ Date: _____

FOR PHARMACY USE ONLY

Vaccine	Lot #	Exp Date	Manufacturer	Dosage	Route	Site	VIS Date
Inactivated Influenza		/ /		0.5 mL	IM	L / R Deltoid	/ /
Pneumococcal		/ /	Merck	0.5 mL	IM	L / R Deltoid	/ /
Herpes Zoster		/ /	Merck	0.65 mL	SC	L / R Arm	/ /
Tdap		/ /		0.5 mL	IM	L / R Deltoid	/ /
		/ /					/ /

Name/Title of Administering Pharmacist: _____

Name/Title of Intern, if applicable: _____

Administration Date: _____

Reported to PCP (Date): _____