Patient Request & Consent for Vaccination

Patient Information					
Name:			Phone:		
Address:					
Date of Birth: Age:		Weight:	Covid-19 only: Race:		Ethnicity:
Primary Provider:					
Allergies:					
Which vaccine(s) are you requesting today?					
○ Flu	○ Covid-19 First dose/Booster	○ Pneumonia	○ Tdap	○ Shingles	○ Other

Please answer the following questions:	Yes	No	Not Sure
Have you had any of the following symptoms in the past 14 days: cough, shortness of breath, or fever greater than 100.4 F?			
Have you been in contact with anyone with confirmed or suspected Coronavirus (COVID-19) within the past 14 days?			
Are you sick today?			
Are you allergic to eggs, latex, or any vaccine component, such as gelatin or neomycin?			
Have you ever had a serious reaction after receiving a vaccination?			
Any history of Guillain-Barre' Syndrome, seizure disorder, or other neurological condition?			
For Women Only: Are you pregnant or is there a chance you could become pregnant during the next month?			

Please list any vaccine(s) you have received in the last 28 days:		Please check any chronic or long-term health conditions you may have:		
○ Shingles	○ Tdap	○ Anemia	○ Asthma	○ Diabetes
○ Pneumonia	○ MMR	○ Heart Disease	○ Lung Disease	○ Kidney Disease
○ Other(s):	○ Covid-19	○ Smoking	○ Other:	

For Patients Receiving Live Vaccines Only: (e.g. Flu (nasal spray), Zostavax, Varivax (chickenpox), and MMR)	Yes	No	Not Sure
Have you received any vaccines in the past 4 weeks?			
Do you have cancer, leukemia, AIDS, or any other immune system problem?			
Have you taken any steroids, anti-cancer drugs, antivirals, immunosuppressive medications, or have you had radiation treatments in the last 3 months?			
In the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin?			

I hereby give my consent to Bashas' pharmacy to administer the vaccines(s) I have requested on this form. I understand the benefits and risks of receiving this vaccine(s). I acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration. I understand that my immunization information will be shared with my prescriber and local immunization registry. As with all medical treatment, there is no guarantee that I will not experience an adverse reaction from the vaccine. If eligible, I authorize Bashas, Inc. to submit a claim for reimbursement on my behalf to Medicare or any other contracted third party payor. If the claim is denied, I understand that I will be responsible for payment. I acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient/Guardian Consent: _____ **Date:** _____

Healthcare Provider Section

This patient received the following vaccine(s) in our pharmacy today as per ACIP recommendations and in conjunction with our vaccination protocol. This data will be uploaded into the vaccination state registry within 24 hours.

Patient Name: _____ **DOB:** _____
Store: _____**Phone:** _____ **Fax:** _____

Place transaction label here.

Place transaction label here.

Vaccine(s) given today:	Route:	Site:	Lot and Expiration Date	VIS Edition Date
Influenza: (Fluarix Quad, Flulaval Quad Fluzone HD, Fluad 65+)	IM	Right Deltoid Left Deltoid		
Pneumonia: Pneumovax , Prevnar 13, Prevnar 20	IM	Right Deltoid Left Deltoid		
Adacel, Boostrix, Tenivac (Tdap, Td)	IM	Right Deltoid Left Deltoid		
Shingrix	IM	Right Deltoid Left Deltoid		
Hepatitis B	IM	Right Deltoid Left Deltoid		
Covid-19: Janssen(Johnson & Johnson)	IM	Right Deltoid Left Deltoid		
Other:				

Certified Immunizer: _____

Immunizer Signature: _____ **Date:** _____ **Time:** _____

Provider Name: _____**Address:**_____**Fax:**_____