Informed Consent for Immunization

Last Name _____ First Name _____ Middle _____ Date of Birth _____ Age _____ ❒ M ❒ F Sex Assigned at Birth

Home Address _____ City _____ State _____ Zip _____ Phone # ( ) - ❒ Home ❒ Mobile

Vaccine(s) requested: ❒ Flu ❒ COVID

Ethnicity: ❒ Hispanic or Latino ❒ Non- Hispanic or Latino ❒ Decline to State

Race: ❒ Asian ❒ American Indian ❒ Pacific Islander ❒ Black or African American ❒ Caucasian ❒ Two or More ❒ Other

If less than 66 pounds list weight: ___Lbs.

Which arm do you prefer for vaccine? ❒ Left ❒ Right

Email address: _____

Primary Care Provider Name: _____

Phone: _____ **Address:** _____

Medicare patients only: Last 4 digits of SSN: _____

Medicare Part B ID#: _____

	Screening Questions	Yes	No
1.	Are you sick today?	❒	❒
2.	Do you have any allergies to medications, food or vaccines? If yes, please list: _____	❒	❒
3.	Have you ever had a serious reaction or fainted after receiving a vaccination (e.g. Guillain-Barré Syndrome)?	❒	❒
4.	For women: Are you pregnant, breastfeeding or are you considering becoming pregnant in the next month? **If pregnant,** gestational week: _____	❒	❒

Do you have Kaiser: Yes _____ No_____

If Kaiser, please write your Medical Record Number (MRN): _____

(Kaiser members should list their Medical Record Number (MRN))

I hereby attest to the following: (1) I am of legal age and authorized to execute this consent form on behalf of myself or the individual receiving the vaccine(s); (2) I voluntarily consent to the administration of the vaccine(s) by an individual legally authorized to administer vaccines who is either employed or contracted by Albertsons Companies, Inc. or one of its affiliated pharmacies ("ACI"); (3) the information I have provided in this form is correct and I, or the person for whom I am consenting, meet eligibility criteria for the vaccine(s); (4) 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"); (5) I have received, read and/or had explained to me the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization(s) ("EUA") for the vaccine(s) to be administered; (6) I understand the risks and benefits of the vaccine(s), including recommended timing for receiving such vaccine(s) and possible side effects; and (7) I have had the opportunity to ask questions and they have been answered to my satisfaction. I understand that I must alert the pharmacist of any medical condition(s) which may impact my ability to safely receive the vaccine(s). I acknowledge that I have been advised to remain in the area for observation for 15 minutes after vaccination, or if there is any history of an allergic reaction of any severity to a vaccine or injectable therapy or of anaphylaxis due to any cause, to remain in the area for 30 minutes after vaccination. I understand that if I leave the area without waiting, I am doing so at my own risk and against medical advice. If an adverse event occurs, I consent to the administration of emergency measures deemed necessary, including administration of epinephrine. On behalf of myself or the patient their heirs and personal representatives, I release ACI and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting from, in connection with, or in any way related to the administration of the vaccine(s). I authorize ACI to submit a claim for reimbursement on my behalf to Medicare, Medicaid, or a third-party payor, including my employer if they are paying for the vaccine(s). If the claim is denied, I agree to be responsible for payment. I acknowledge this vaccination may be subject to reporting to my state's immunization registry or health department and subsequent sharing with other healthcare providers. Depending on my state laws, I understand that I may be able to opt out of such reporting by following the requirements set by my state, including notifying ACI of my preference where applicable. If my state requires express consent for such data sharing, my signature below evidences my consent unless I have expressly indicated otherwise to ACI. (New Jersey only: I authorize do not authorize ___reporting of my receipt of this vaccination to my primary care provider; failure to check authorize/do not authorize will serve as authorization.) For parents/guardians of minor patients, I confirm I have received written notice to visit a pediatrician annually. By signing below, I acknowledge and agree with the above statements and give my consent for vaccination.

X _____

Signature of Patient or Parent/Guardian of Minor Patient (put relationship to minor) **Printed Name** **Date**

Vaccine Name	Lot #	Expiration Date	Manufacturer	Dose (ml)	Dose #	Route	Site (circle)	VIS/EUA Pub. Date
Flu (_____)				*0.5*	*N/A*	*IM*	*R / L Deltoid*	
COVID-19 (_____)					*N/A*	*IM*	*R / L Deltoid*	
						IM	*R / L* _____	
							R / L _____	
							R / L _____	

Ordering RPh Signature: _____ **Name of Administrator:** _____ **Admin/VIS Provided Date:** _____ ❒ **NPP Offered**

Counseling (Please circle): Accepted / Declined ❒ **Offsite Clinic** **Clinic Name:** _____ **Clinic Address:** _____

Appt Date: _____ **Appt Time:** _____ **Administration time (OR Only):** _____

***WA ONLY*: Substitution Permitted** _____ **Dispense as Written:** _____ ICIMZIV20250605