Vaccine Informed Consent Form

First Name:	Last Name:	Date of Birth:	Gender:
Address (Street, City, State, Zip):			
Home Phone:	Cell Phone:	Physician:	City:
Race/Ethnicity:			
☐ American Indian or Alaska Native	☐ Black or African American	☐ White	☐ Other
☐ Hispanic or Latino American	☐ Pacific Islander	☐ Asian	

I want to receive the following immunization(s):

☐ Flu (Quad)

☐ Flu (65+)

Please answer each question by checking the appropriate boxes. If a question is not clear, please ask.

This section to be completed for <u>all</u> vaccines.	**Yes**	**No**	**Don't Know**
1) Are you sick today?			
2) Do you have allergies to medications, food, a vaccine component or latex?			
3) Have you ever had a serious reaction after receiving a vaccination?			
4) Have you had a seizure, Guillan-Barre syndrome, brain or other nervous system problem?			
5) For women: Are you pregnant or is there a chance you could become pregnant during the next month?			

I agree that Big Y Pharmacy will notify my physician of vaccine received. If applicable, I give Big Y Pharmacy permission to bill Medicare Part B on my behalf for vaccine. RISKS AND POSSIBLE SIDE EFFECTS –Any vaccine may cause some side effects. The most commonly reported side effects may include soreness at the injection site and, with the flu vaccine, "mild" flu-like symptoms. Rare side effects may include allergic reaction and Guillain-Barre syndrome. If you experience unusual or severe symptoms after receiving any vaccination, please contact your health care provider immediately. I have received and read the vaccine information statement for vaccine(s) administered and explanations of possible adverse effects for the vaccinations and have had the opportunity to ask questions. I understand the benefits and risks of the vaccine and I consent to the administration of the vaccine. I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering health care professional. Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators, and assignees, Big Y Foods, Inc. and their employees, owners, and representatives from any and all claims, demands, actions, and causes of action, which may result from participation in this program. I will communicate the information provided to me today about my vaccination to my primary care provider if I have one.

Patient or Parent/Legal Guardian: _____ **Date:** _____/_____/_____

If Parent/Legal Guardian, please print name and relation to patient: _____

Prescription Insurance Information:

BIN:		Medicare Part B	
PCN:		CT Medicaid	
Cardholder ID:		MassHealth	
Rx Group:		OTHER	

Place store stamp here:

Notification of Vaccine Administered / Patient Record

Attn Provider: _____ Fax:_____

On _____/_____/_____, Big Y Pharmacy administered the following vaccination(s) to your patient:

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ Date: _____

RX:

Vaccine Administered	Route	Dosage	Lot #	Expiration Date	Injection Site	VIS Date
Influenza (Quadrivalent)	IM	0.5 ml			Deltoid: Left / Right	8/15/19
Influenza (65+)	IM				Deltoid: Left / Right	8/15/19

SIG: To be administered

ICD10: **Z23**

Prescriber: Robert Wool DEA AW1427601

Immunizer: _____, RPh Admin Date: _____/_____/_____