

Universal Immunization Consent Form (AR)

Circle vaccine requested: flu, COVID-19, shingles, other: _____
To be completed by pharmacy staff

Name (as it appears on insurance card): _____ Date of Birth: _____ Age: _____ Gender: Male / Female

Street Address: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ @ _____

Please contact me about screenings, immunization clinics and other promotions.

Phone Number: _____

Insurance:

Social Security Number: _____

or

Medicare Number: _____

Will be used for billing insurance for the administration fee of vaccines.

Primary Care Provider: _____

MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine.

**If you answer yes to any of the questions below, please discuss this with a staff member prior to receiving the vaccine	**YES	NO
Are you sick today?		
Do you have allergies to medications, food, a vaccine ingredient, or latex? If yes please list:		
Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component or injectable therapy? (including Pfizer-BioNTech or Moderna COVID-19 vaccine) Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness, and weakness.		
Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe obesity, do you smoke or have diabetes mellitus?		
Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?		
Have you had a seizure or a brain or other nervous system problem?		
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?		
Have you received any vaccinations in the past 4 weeks?		
Are you pregnant, breastfeeding or planning to become pregnant?		

For patients receiving the COVID-19 vaccine, please answer these additional screening questions below

Have you had a previous COVID-19 vaccine? If yes, which one: Pfizer, Moderna, J&J, Other: _____ (Circle one) / Date of last dose: _____		
Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Pfizer-BioNTech or Moderna COVID-19 vaccine should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced immune responses.		

NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine **may** be due in 21 days or 28 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date.

Section 2: RELEASE AND ASSIGNMENT:

Consent and waiver: I consent to the staff to administer the medication(s) mentioned below. - I have reviewed the vaccine information sheet (s) and understand the benefits and risks of receiving this medication and choose to assume this risk. - I fully release and discharge the protocol physician and the pharmacy, its affiliations and their officers, and employees from any illness, injury, loss, or damage that may result there from. - I acknowledge that I have been offered and / or reviewed a copy of the pharmacy's privacy policies according to HIPAA. - I consent the release of medical information when necessary for billing, reimbursement, and medical protocol. - I am aware that an immunization certified student pharmacist might be administering this medication. - I also allow for the pharmacy to report any medications received to the appropriate state vaccine registry. - I agree to wait near the vaccination area for approximately 20 minutes to receive treatment in case of adverse reaction.

COVID Vaccine Addendum:

- I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient Emergency Use Authorization Fact Sheet for each vaccine visit the website www.cvdvaccine.com; or you may also visit the Local Health Unit or private provider to receive a printed copy of the EUA Fact Sheet. To read the Vaccine Recipient Emergency Use Authorization for Moderna COVID-19 vaccine visit the website https://www.fda.gov/media/144638/download or (modernatx.com) - I give consent to this COVID-19 provider/staff for the individual named below to be vaccinated with COVID-19 vaccine.
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To My Insurance Carrier(s):

- I authorize the release of any medical information necessary to process my insurance claim(s). - I authorize and request payment of medical benefits directly to this Provider. - I agree that the authorization will cover all medical services rendered until I revoke the authorization. - I agree that the photocopy of this form may be used instead of the original.
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My signature below indicates I have read, understand and agree to section 2. Release and Assignment of the Immunization Consent Form, Vaccine Information Sheet and / or Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).

Signature of patient or guardian X: _____ Date: _____

Below is for pharmacy documentation:

Medication: _____	Mfg: _____	Amt: _____	VIS Date: ____/____/____	Lot: _____	Exp Date: ____/____/____	Site: Deltoid IM / Arm SC Left / Right
Medication: _____	Mfg: _____	Amt: _____	VIS Date: ____/____/____	Lot: _____	Exp Date: ____/____/____	Site: Deltoid IM / Arm SC Left / Right
Medication: _____	Mfg: _____	Amt: _____	VIS Date: ____/____/____	Lot: _____	Exp Date: ____/____/____	Site: Deltoid IM / Arm SC Left / Right

Administered by: _____ Title: _____ Date Given: _____



Pharmacist
Immunization
Program
Improving Arkansas wellness.