SAAR'S INFORMED CONSENT TO RECEIVE VACCINES

First Name _____ *MI* _____ *Last Name* _____

Home/Cell Phone _____ *Date of Birth (mm/dd/yyyy)* _____ *Age* _____ *M F Gender*

Home Address _____ *City* _____ *State* _____ *Zip Code* _____

Email Address _____ *SS# - OR - Driver's License State and #* _____

____ American Indian or Alaska Native; ___ Native Hawaiian or Pacific Islander; ___Asian; ___ Black/African American; ___ White; ___Hispanic/Latino; ___Other

	The following questions will help us determine your eligibility to be vaccinated today.	Yes	No	Don't Know
	1. Do you have a fever or illness today?	___	___	___
	2. Have you experienced any of the following in the past 14 days: fever, unusual cough, unusual shortness of breath?	___	___	___
	3. Have you or a household contact been diagnosed with COVID-19 in the past 14 days?	___	___	___
	4. Do you have allergies to medications, food (e.g. eggs), latex, or a vaccine component (e.g. bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol or thimerosal)?. If yes, please list the allergies _____	___	___	___
	5. Have you been diagnosed with heart inflammation (myocarditis or pericarditis) in the past?	___	___	___
	6. Have you received any convalescent plasma or COVID-19 antibodies in the past 90 days?	___	___	___
	7. Have you ever had a serious reaction to an influenza vaccine or any other vaccine in the past?	___	___	___
	8. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem?	___	___	___
	9. Are you 65 years of age or older?	___	___	___
	10. Do you have a chronic condition or long-term health problem**? If yes, please check all that apply.** ___Anemia ___Asthma ___Diabetes ___Heart disease ___Kidney disease ___Liver disease ___Lung disease ___Smoker	___	___	___
	11. Have you ever had a pneumonia vaccination?	___	___	___
	12. Have you ever had a shingles vaccination (for patients 50 years of age and older only)?	___	___	___
	13. **For women**: Are you pregnant or considering becoming pregnant in the next month?	___	___	___
LIVE VACCINES	14. For the past 3 months, have you taken medications that affect your immune system, such as prednisone or other steroids, anti-cancer drugs, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis; or have you had radiation treatments?	___	___	___
	15. 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?	___	___	___
	16. Have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?	___	___	___
	17. Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your thymus removed? (yellow fever only)	___	___	___
	18. Do you have a history of thrombocytopenia or thrombocytopenia purpura? (for MMR® II only)	___	___	___
	19. Have your consumed any food or drink in the last hour? (for Vaxchora® only)	___	___	___
	20. Have you taken antibiotics in the last 14 days or antimalarials in the last 10 days? (Vaxchora® only)			

I have read, or have had read to me, the Vaccine Information Statement (VIS) referred to above. I have had the opportunity to ask questions about the vaccine(s), and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to the administration of the vaccine(s) requested. I authorize the information to be forwarded to my primary care physician, the authorizing physician, Washington State Immunization Information System, or the local Dept. of Health, if applicable. **I agree to stay in the general area for 15 minutes** after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); the subsidiaries and affiliates of the pharmacy; the respective directors, officers, employees, and agents of the pharmacy and its subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability that might arise from this vaccination.

Patient Signature: _____ Date: _____

(Parent or Guardian, if minor)

Please initial that you have received our Notice of Privacy Practice for HIPAA

_____

INSURANCE INFORMATION
(Please give your insurance card AND to the pharmacy staff (**OR PLEASE include images below**)

Primary Insurance:
Subscriber's Name: Date of birth:
Group No:
Policy No:
Client's relationship to subscriber:

Secondary Insurance:
Subscriber's Name: Date of birth:
Group No:
Policy No:
Client's relationship to subscriber:

Medicare#
SS#

The above information is true to the best of my knowledge. If qualified, I authorize billing to my insurance company and release of information required to process my claims.
Client Signature Date
_____Insurance Card AND Identification images b