Franciscan HEALTH
IMMUNIZATION SERVICES

Adult Consent form 18 & Older

Legal Name: _____Birthdate: _____ Age: _____

Social Security Number _____ Legal Sex: M or F Sex at Birth: M or F Gender Identity:_____

Hispanic or Non-Hispanic Race: _____ Primary Language: _____

Married Status: _____ Religious Pref: _____

Address: _____ City: _____

State: _____ Zip: _____Phone Number: _____

Employer: _____ Family Dr name: _____

Primary Insurance Company: _____ Member ID: _____

Group ID: _____ Insurance Company phone Number: _____

Policy Holder: _____Relationship to Patient:_____ Birthdate: _____

Employer: _____

Medical History: **The following will help us determine your eligibility for requested immunizations. Please answer to the best of your ability.**

1. Are you pregnant or planning a pregnancy in the next 4 weeks?	**YES**	**NO**
2. Are you currently ill with a fever, vomiting or diarrhea?	**YES**	**NO**
3. Have you ever fainted, became dizzy or had a serious reaction after an immunization?	**YES**	**NO**
4. Are you allergic to any medications, foods or vaccines and their components? (Such as eggs, bovine protein, toxoids, sorbitol, neomycin, phenol, yeast, thimerosal, latex, protamine sulfate, formaldehyde, hypersensitivity to gelatin)	**YES**	**NO**

ACKNOWLEDGEMENT/ RELEASE OF LIABILITY AND CONSENT TO RECEIVE IMMUNIZATION(S):

- I HAVE READ OR HAVE BEEN OFFERED A COPY OF THE CURRENT VACCINE INFORMATION SHEET PRIOR TO MY VACCINATION. I HAVE HAD A CHANCE TO ASK QUESTIONS AND I UNDERSTAND ALL THE RISKS AND BENEFITS INVOLVED.
- I AGREE TO STAY IN THE AREA FOR 15 MINUTES AFTER RECEIVING MY VACCINATION TO ENSURE THAT NO IMMEDIATE REACTIONS OCCUR. I UNDERSTAND THAT IF I EXPERIENCE ANY SIDE EFFECTS IT WILL BE MY RESPONSIBILITY TO FOLLOW UP WITH MY PHYSICAN AT MY EXPENSE. LOCAL REACTIONS MAY INCLUDE BURNING, SWELLING, REDNESS, TENDERNESS OR BLISTERING AT THE SITE. GENERAL REACTIONS MAY INCLUDE FEVER, FATIGUE, DIARRHEA, NAUSEA, VOMITING, HEADACHE, ARTHRITIS, MALAISE AND MYALGIA. SEVERE REACTIONS INCLUDE ANAPHYLAXIS, ENCEPHALITIS, GUILLAIN-BARRE AND FEBRILE CONVULSIONS.
- I UNDERSTAND THE VACCINE IS BEING PROVIDED BY FRANCISCAN IMMUNIZATIONS. I RELEASE FROM ANY LIABILITY THE ABOVE-NAMED ORGANIZATION AND INDIVIDUAL GIVING THE VACCINE(S). I, FOR MYSELF, MY HEIRS, EXECUTORS AND ASSIGNS HEREBY AGREE TO RELEASE THE SITE PROVIDER AND ITS EMPLOYEES FROM ANY AND ALL CLAIMS ARISING OUT OF, IN CONNECTION WITH OR IN ANY WAY RELATED TO MY RECEIPT OF THIS VACCINE(S) IN THEIR FACILITIES.
- I HAVE READ THIS CONSENT AND I AUTHORIZE FRANCISCAN IMMUNIZATIONS TO GIVE THE ABOVED NAMED VACCINE TO ME OR THE PERSON NAMED FOR WHICH I AM AUTHORIZED TO SIGN.
- I ACKNOWLEDGE THAT SOME VACCINES REQUIRE MULTIPLE DOSES AND/OR UP TO 2 WEEKS TO RECEIVE FULL PROTECTION.
- **ASSIGNMENT OF BENEFITS**: I HEREBY AUTHORIZE ANY INSURANCE WITH WHOM I HAVE A POLICY TO PAY DIRECTLY TO THE HEALTHCARE PROVIDERS ANY BENEFITS OTHERWISE PAYABLE TO ME. I HEREBY TRANSFER AND ASSIGN THE BENEFITS OF ANY POLICIES OF INSURANCE TO THOSE HEALTHCARE PROVIDERS WHO HAVE RENDERED SERVICES TO ME AND WHO ACCEPT SUCH ASSIGNMENT. **I UNDERSTAND THAT I WLL BE FULLY RESPONSIBLE FOR PAYMENT OF ANY AND ALL CHARGES NOT PAID BY MEDICAL INSURANCE. IF ANY AMOUNTS FOR WHICH I AM RESPONSIBLE BECOME DELINQUENT, I AGREE TO BE RESPONSIBLE FOR ANY EXPENSES PAID BY FRANCISCAN ALLIANCE AND HEALTHCARE PROVIDERS TO COLLECT THE AMOUNTS, INCLUDING REASONABLE ATTORNEY FEES.**
- I UNDERSTAND THAT THERE MAY BE A DELAY, WHICH COULD BE MORE THAN 6 MONTHS, BETWEEN THE TIME I SIGN THIS CONSENT AND WHEN THE IMMUNIZATIONS ARE GIVEN TO MY CHILD. AS SUCH, I AGREE THAT IT IS MY SOLE RESPONSIBILITY TO MAINTAIN A COPY OF THIS CONSENT, TO NOTIFY THE SCHOOL OR FRANCSICAN IMMUNIZATIONS, AND TO PROVIDE AN UPDATED CONSENT IF MY ANSWERS CHANGE, OR MY CHILDS HEALTH CHANGES.

PLEASE NOTE THAT IF YOU HAVE NOT ANSWERED OR FILLED OUT ALL INFORMATION, WE WILL NOT VACCINATE.

X_____ _____

Patient Signature (parent or guardian if patient is under 18), Offered/Read HIPAA Privacy Practices Date

Full Dose Flu 0.5 ml	Manufacturer	Route IM R arm L R Thigh L	Lot Number & exp Date	Tdap 0.5ml	GSK	R arm L	Lot Number & exp Date
Flu Mist	AstraZeneca	Nasal		Shingrix 0.5ml	GSK	R arm L	
High Dose Flu 0.5ml	Sanofi Sequirus	R arm L		Pneumonia 20 0.5ml	Pfizer	R arm L	
Flubok 0.5ml	Sanofi	R arm L		Covid		R arm L	

Staff Signature: