Informed Consent to Receive Vaccines 2023-2024

First Name: _____ **Last Name:** _____ **Date of Birth:** _____ **Age:** _____
(Legal name and / or how it appears on your insurance card)

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Mobile / Land** (circle one)

Drug Allergies: _____

Gender: _____ **Ethnicity:** Hispanic or Latino Non-Hispanic or Latino Decline to State (Unknown)

Race: Asian African-American Hispanic American Indian Caucasian/white Pacific Islander Two or More Other

Do you have Medicare B? **Yes:** Medicare **B** ID#: _____ ***or*** last 4 of SSN: _____

No: Please complete the below with your pharmacy / medical insurance information:

Pharmacy Insurance Name:
Rx ID # (include any letters):
Rx Group #:
Rx BIN:
Rx PCN:

Medical Insurance Name:
ID # (include any letters):
Group #:
Payer ID:

If uninsured, please circle: **Uninsured**

	Please answer Yes or No to the questions below. If any questions are unclear, please ask for help.	**Yes**	**No**	**Don't Know**
1)	Are you feeling sick today (fever, diarrhea, vomiting)?			
2)	Have you ever had a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine (EpiPen®) or that caused you to go to the hospital, including an allergic reaction that occurred within 4 hours that caused hives, swelling, respiratory distress, or wheezing to any of the following:			
	• Baker's yeast, preservatives (i.e. sulfites), thimerosal, streptomycin, neomycin, arginine, gelatin, **latex**, polysorbate/polyethylene glycol (PEG), vaccines, or any other injectable medication?			
3)	Do you have a long-term health problem such as heart disease, lung disease, asthma, kidney disease, diabetes, or blood disorders?			
4)	Have you received Immune (gamma) Globulin or a transfusion of blood in the past year?			
5)	Have you had Guillain-Barre Syndrome, a condition which causes paralysis?			
6)	Do you have a bleeding disorder or are you taking a blood thinner?			
7)	Do you or anyone in your household have a weakened immune system caused by something such as HIV infection or cancer or take immunosuppressive drugs or therapies?			
8)	Have you received any other vaccine in the past 4 weeks?			
9)	Are you pregnant or breastfeeding?			

By signing, you acknowledge you have reviewed the disclosure on page 2 of this form and have received our HIPAA Notice of Privacy Practices.
**Parent or guardian signature required for patients under the age of 18 years*

***Patient Signature:** _____ **Date:** _____

The immunizer will review this form with you before giving the immunization. Based on your answers, we may refer you to speak with your physician to make sure the vaccine is right for you. If you have ever experienced syncope (fainting) after immunization administration in the past, please notify the immunizer prior to administration.

***** I understand it is also important for children to have routine checkups performed by a pediatrician or other licensed primary-care provider. During "well care" checkups, the provider may perform a physical examination, order laboratory tests, do vision and hearing screenings, etc. These checkups can detect medical problems so that they can be treated.

I have read, or have had read to me, the provided Emergency Use Authorization(s) ("EUA") or Vaccine Information Statement(s) ("VIS"). 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. I consent to the administration of the vaccine requested. I authorize the release of this information to authorized third parties and assign any payment benefit due to this transaction to the pharmacy mentioned above. I understand that immunizations may or may not be covered by my insurance coverage and that I may be responsible for some, or all, of the vaccine cost and administration charges I authorize this information to be forwarded to my primary care physician, the authorizing physician, or the local Dept. of Health, if applicable. **I agree to stay in the general area for 15 to 30 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); SUPERVALU INC.; the subsidiaries and affiliates of SUPERVALU INC.; the respective directors, officers, employees, and agents of SUPERVALU INC. 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.
By providing my home, work and/or cellular telephone number, I authorize Supervalu, Inc. and its agents to contact me at the number(s) provided, including by calling or texting me using an autodialer or pre-recorded messages, to communicate with me about any of the pharmacy products or services that I have received from Supervalu, Inc. This includes, but is not limited to, contacting me about refill reminders and when future vaccines are due for administration. I understand that message and data rates may apply and that I will have the option of stopping or opting-out of receiving future messages. I understand that I am not required to allow Supervalu, Inc. and its agents to contact me at the number(s) provided above in order to purchase products or services from Supervalu, Inc.

For easy access to your personal and family immunization records at no cost, scan the QR code to download the **docket app**, a partner of the MN Department of Health.

Vaccine Information *(Staff Use Only)*

Vaccine #1	
Manufacturer	
Lot #	
Exp. Date	
VIS/EUA revision date	
Inject IM / SQ	Right or Left Arm
Dose (mL)	
Admin/EUA/VIS given date	
Patient Age	
Store #	
Administrator**	

Rx Barcode

Vaccine #2	
Manufacturer	
Lot #	
Exp. Date	
VIS/EUA revision date	
Inject IM / SQ	Right or Left Arm
Dose (mL)	
Admin/EUA/VIS given date	
Patient Age	
Store #	
Administrator**	

Rx Barcode

**By signing as administrator, you are confirming: the appropriate immunization registry, contraindications, and side effects have been reviewed, and a current EUA or VIS was provided to the patient receiving vaccine.
Additional notes, if applicable: