Record with you to your next appointment as well.

This pharmacy is providing necessary vaccines to you in a safe and convenient setting to promote adherence to current immunization guidelines recommended by the CDC and ACIP. It does not take the place of an ongoing relationship with your primary care provider to address ongoing medical issues and other types of preventive care. We communicate the administration of the Vaccine to the Patient’s listed primary care provider.

I have read, or had explained to me, the Vaccine Information Statement, Emergency Use Authorization, or applicable fact sheet for the Vaccine. I understand the risks and benefits, and will be provided an opportunity to ask questions, which have or will be answered to my satisfaction prior to the Patient’s receipt of the Vaccine. I wish for the Patient to receive the Vaccine and hereby give consent for the Public Vaccine Provider to administer the Vaccine and

I have truthfully answered all the questions regarding the Patient’s medical history that are listed above. I understand that if I answered a question with a "Yes," there is an increased likelihood that the Patient will experience an adverse reaction from the administration of the Vaccine. After careful consideration, I believe that the benefits of the Patient receiving the Vaccine outweigh the risks associated with receiving the Vaccine and I have decided to allow the Public Vaccine Provider to administer the Vaccine to the Patient.

By allowing the Public Vaccine Provider to physically administer the Vaccine to the Patient, I agree I fully understand all risks and benefits in connection with the Vaccine and all my questions have been answered to my satisfaction. I understand I may choose for the Patient not to receive the Vaccine and will not be charged for the cancellation.

Please review the statement below confirming your consent for vaccination and provide the information requested.

For live and inactivated vaccines:

For Minors and Unemancipated Minors:

Alternatively, the consent giver must be an individual with the legal capacity to consent for the Patient, such as a parent, legal guardian, or authorized health care surrogate.

For live vaccines:

For persons age 18 years or older:

This pharmacy is providing necessary vaccines to you in a safe and convenient setting in order to promote adherence to current immunization guidelines recommended by the CDC and ACIP. It does not take the place of an ongoing relationship with your primary care provider to address ongoing medical issues and other types of preventive care. We communicate the administration of the Vaccine to the Patient’s listed primary care provider. I understand the risks and benefits, and will be provided an opportunity to ask questions, which have or will be answered to my satisfaction prior to the Patient’s receipt of the Vaccine. I wish for the Patient to receive the Vaccine and hereby give consent for the Public Vaccine Provider to administer the Vaccine and

I have truthfully answered all the questions regarding the Patient’s medical history that are listed above. I understand that if I answered a question with a "Yes," there is an increased likelihood that the Patient will experience an adverse reaction from the administration of the Vaccine. After careful consideration, I believe that the benefits of the Patient receiving the Vaccine outweigh the risks associated with receiving the Vaccine and I have decided to allow the Public Vaccine Provider to administer the Vaccine to the Patient.

By allowing the Public Vaccine Provider to physically administer the Vaccine to the Patient, I agree I fully understand all risks and benefits in connection with the Vaccine and all my questions have been answered to my satisfaction. I understand I may choose for the Patient not to receive the Vaccine and will not be charged for the cancellation.

Please review the statement below confirming your consent for vaccination and provide the information requested.

For purposes of this consent “I,” “me,” “my,” “you,” and “your” refer to the consent-giver or the Patient as the context requires. The consent-giver must be the Patient if the Patient possesses the legal capacity to consent (e.g., is not an unemancipated minor). Alternatively, the consent-giver must be an individual with the legal capacity to consent for the Patient, such as a parent, legal guardian, or authorized health care surrogate.

I voluntarily request and consent that a Publix Vaccine Provider administer the selected vaccine for which this appointment is being made (“Vaccine”) to the Patient for whom this appointment is being made (“Patient”). I understand the “Publix Vaccine Provider” is either a pharmacist, pharmacy intern, or pharmacy technician, employed or contracted by Publix Super Markets, Inc. (“Publix”) or an affiliate or subsidiary of Publix.

I understand this pharmacy is providing necessary vaccines to the Patient in a safe and convenient setting to promote adherence to current immunization guidelines recommended by the CDC and ACIP. It does not take the place of an ongoing relationship with your primary care provider to address ongoing medical issues and other types of preventive care. We communicate the administration of the Vaccine to the Patient’s listed primary care provider.

I understand the risks and benefits, and will be provided an opportunity to ask questions, which have or will be answered to my satisfaction prior to the Patient’s receipt of the Vaccine. I wish for the Patient to receive the Vaccine and hereby give consent for the Public Vaccine Provider to administer the Vaccine and

I have truthfully answered all the questions regarding the Patient’s medical history that are listed above. I understand that if I answered a question with a "Yes," there is an increased likelihood that the Patient will experience an adverse reaction from the administration of the Vaccine. After careful consideration, I believe that the benefits of the Patient receiving the Vaccine outweigh the risks associated with receiving the Vaccine and I have decided to allow the Public Vaccine Provider to administer the Vaccine to the Patient.

By allowing the Public Vaccine Provider to physically administer the Vaccine to the Patient, I agree I fully understand all risks and benefits in connection with the Vaccine and all my questions have been answered to my satisfaction. I understand I may choose for the Patient not to receive the Vaccine and will not be charged for the cancellation.

Please review the statement below confirming your consent for vaccination and provide the information requested.

For purposes of this consent “I,” “me,” “my,” “you,” and “your” refer to the consent-giver or the Patient as the context requires. The consent-giver must be the Patient if the Patient possesses the legal capacity to consent (e.g., is not an unemancipated minor). Alternatively, the consent-giver must be an individual with the legal capacity to consent for the Patient, such as a parent, legal guardian, or authorized health care surrogate.

I voluntarily request and consent that a Publix Vaccine Provider administer the selected vaccine for which this appointment is being made (“Vaccine”) to the Patient for whom this appointment is being made (“Patient”). I understand the “Publix Vaccine Provider” is either a pharmacist, pharmacy intern, or pharmacy technician, employed or contracted by Publix Super Markets, Inc. (“Publix”) or an affiliate or subsidiary of Publix.

I understand this pharmacy is providing necessary vaccines to the Patient in a safe and convenient setting to promote adherence to current immunization guidelines recommended by the CDC and ACIP. It does not take the place of an ongoing relationship with your primary care provider to address ongoing medical issues and other types of preventive care. We communicate the administration of the Vaccine to the Patient’s listed primary care provider.

I understand the risks and benefits, and will be provided an opportunity to ask questions, which have or will be answered to my satisfaction prior to the Patient’s receipt of the Vaccine. I wish for the Patient to receive the Vaccine and hereby give consent for the Public Vaccine Provider to administer the Vaccine and

I have truthfully answered all the questions regarding the Patient’s medical history that are listed above. I understand that if I answered a question with a "Yes," there is an increased likelihood that the Patient will experience an adverse reaction from the administration of the Vaccine. After careful consideration, I believe that the benefits of the Patient receiving the Vaccine outweigh the risks associated with receiving the Vaccine and I have decided to allow the Public Vaccine Provider to administer the Vaccine to the Patient.

By allowing the Public Vaccine Provider to physically administer the Vaccine to the Patient, I agree I fully understand all risks and benefits in connection with the Vaccine and all my questions have been answered to my satisfaction. I understand I may choose for the Patient not to receive the Vaccine and will not be charged for the cancellation.

Please review the statement below confirming your consent for vaccination and provide the information requested.

For purposes of this consent “I,” “me,” “my,” “you,” and “your” refer to the consent-giver or the Patient as the context requires. The consent-giver must be the Patient if the Patient possesses the legal capacity to consent (e.g., is not an unemancipated minor). Alternatively, the consent-giver must be an individual with the legal capacity to consent for the Patient, such as a parent, legal guardian, or authorized health care surrogate.

I voluntarily request and consent that a Publix Vaccine Provider administer the selected vaccine for which this appointment is being made (“Vaccine”) to the Patient for whom this appointment is being made (“Patient”). I understand the “Publix Vaccine Provider” is either a pharmacist, pharmacy intern, or pharmacy technician, employed or contracted by Publix Super Markets, Inc. (“Publix”) or an affiliate or subsidiary of Publix.

I understand this pharmacy is providing necessary vaccines to the Patient in a safe and convenient setting to promote adherence to current immunization guidelines recommended by the CDC and ACIP. It does not take the place of an ongoing relationship with your primary care provider to address ongoing medical issues and other types of preventive care. We communicate the administration of the Vaccine to the Patient’s listed primary care provider.

I understand the risks and benefits, and will be provided an opportunity to ask questions, which have or will be answered to my satisfaction prior to the Patient’s receipt of the Vaccine. I wish for the Patient to receive the Vaccine and hereby give consent for the Public Vaccine Provider to administer the Vaccine and

I have truthfully answered all the questions regarding the Patient’s medical history that are listed above. I understand that if I answered a question with a "Yes," there is an increased likelihood that the Patient will experience an adverse reaction from the administration of the Vaccine. After careful consideration, I believe that the benefits of the Patient receiving the Vaccine outweigh the risks associated with receiving the Vaccine and I have decided to allow the Public Vaccine Provider to administer the Vaccine to the Patient.

By allowing the Public Vaccine Provider to physically administer the Vaccine to the Patient, I agree I fully understand all risks and benefits in connection with the Vaccine and all my questions have been answered to my satisfaction. I understand I may choose for the Patient not to receive the Vaccine and will not be charged for the cancellation.

Please review the statement below confirming your consent for vaccination and provide the information requested.

For purposes of this consent “I,” “me,” “my,” “you,” and “your” refer to the consent-giver or the Patient as the context requires. The consent-giver must be the Patient if the Patient possesses the legal capacity to consent (e.g., is not an unemancipated minor). Alternatively, the consent-giver must be an individual with the legal capacity to consent for the Patient, such as a parent, legal guardian, or authorized health care surrogate.

I voluntarily request and consent that a Publix Vaccine Provider administer the selected vaccine for which this appointment is being made (“Vaccine”) to the Patient for whom this appointment is being made (“Patient”). I understand the “Publix Vaccine Provider” is either a pharmacist, pharmacy intern, or pharmacy technician, employed or contracted by Publix Super Markets, Inc. (“Publix”) or an affiliate or subsidiary of Publix.

I understand this pharmacy is providing necessary vaccines to the Patient in a safe and convenient setting to promote adherence to current immunization guidelines recommended by the CDC and ACIP. It does not take the place of an ongoing relationship with your primary care provider to address ongoing medical issues and other types of preventive care. We communicate the administration of the Vaccine to the Patient’s listed primary care provider.

I understand the risks and benefits, and will be provided an opportunity to ask questions, which have or will be answered to my satisfaction prior to the Patient’s receipt of the Vaccine. I wish for the Patient to receive the Vaccine and hereby give consent for the Public Vaccine Provider to administer the Vaccine and

I have truthfully answered all the questions regarding the Patient’s medical history that are listed above. I understand that if I answered a question with a "Yes," there is an increased likelihood that the Patient will experience an adverse reaction from the administration of the Vaccine. After careful consideration, I believe that the benefits of the Patient receiving the Vaccine outweigh the risks associated with receiving the Vaccine and I have decided to allow the Public Vaccine Provider to administer the Vaccine to the Patient.

By allowing the Public Vaccine Provider to physically administer the Vaccine to the Patient, I agree I fully understand all risks and benefits in connection with the Vaccine and all my questions have been answered to my satisfaction. I understand I may choose for the Patient not to receive the Vaccine and will not be charged for the cancellation.
I have provided true, complete, and accurate information identifying the Patient’s applicable health care plan/insurance coverage, if any. I authorize Publix to submit a claim to the Patient’s health care plan/insurer for this service and hereby assign the Patient’s rights to health care plan/insurance benefits to collect any available benefits due with respect to such claim to Publix, its affiliate, or subsidiary. I will be financially responsible for any co-pays, coinsurance, and deductibles for the requested services as well as for any services not covered by the Patient’s health care plan/insurance benefits.

I authorize Publix to use and/or disclose such information about the Patient, including any medical related information that I provide to Publix, its affiliate or subsidiary, on that is created or received by Publix, its affiliate or subsidiary, that Publix reasonably determines is necessary to receive payment for its services, carry out treatment for the Patient, or conduct healthcare operations. This authorization includes disclosures to regulatory agencies, Medicare, Medicaid, and other governmental authorities, reports to regulators, and related legal compliance reports. The authorization includes the disclosure of information to third parties such as health plans, insurers, pharmacy benefit managers, claims processors, billing companies, interpreters, and other persons involved in the Patient’s treatment or payment for the Patient’s treatment, as well as any federal or state and local health departments or other persons involved in managing healthcare operations, or for telemarketing and advertising care alternatives and other benefits, products, and services that may be of interest. You understand that texts and push notifications are not secure. If others intercept the messages or access the device, they will be able to see confidential health information. You understand that you need not agree as a condition to purchase any goods or services.

Signature of Patient or Legal Guardian

Relation to Patient (if not Patient)

Date

For Publix Use Only:

Billing (select one): Medicare Medicare Choice Publix Associate, Family Member, Other (specify: )

Vaccine Administration Record

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Dose</th>
<th>Vaccine</th>
<th>Lot #</th>
<th>Expiration</th>
<th>Manufacturer</th>
<th>Date Given (mo/day/yr)</th>
<th>Route (IM, SQ)</th>
<th>Site Given (RA, LA)</th>
<th>Vaccine Information Statement Date on VIS</th>
<th>Date Given</th>
</tr>
</thead>
</table>

Primary Care Provider Notification (Required in South Carolina)

Staple a copy of the Provider Notification to this hard copy.

Completed

Patient Does Not Have Primary Care Provider

Adverse Reaction Log

(In addition to this log, Pharmacist or Intern must complete and submit VAERS report)

Date and Time of Adverse Reaction:

Describe Adverse Reaction of the Vaccine(s) (e.g., shortness of breath, angioedema, chest pain, syncope, rash, etc.): 

Describe Interventions (include medications and dosage, CPR, etc. for adverse reaction): 

Disposition, home, EMS, etc.:

Signature of Pharmacy Intern (if applicable)

Signature of Pharmacist or Pharmacist Supervising Pharmacy Intern

Date

Place a copy of the prescription label here: