Pharmacy

IMMUNIZATION CONSENT FORM – SOUTH CAROLINA

Name:_____Birth date:___/____/____Age:_____Sex: (M/F)_____

Address:_____City:_____State:____Zip:_____

Phone: (____)_____Medicare ID# (including alpha):_____Publix Associate Personnel #:_____

Primary Care Practitioner: _____ Select vaccines to be administered:

☐ Influenza (Flu) ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis Combo (A & B) ☐ HPV ☐ Meningococcal

☐ MMR ☐ Pneumococcal ☐ Td/Tdap ☐ Zoster (Shingles) ☐ Other:_____

	Precautions and Contraindications: Please mark YES or NO for each question.	**YES**	**NO**
For Inactive and Live Vaccines	For Flu Shot: Are you 12 years of age or older? For Other Vaccines: Are you 18 years of age or older?		
	Are you sick today? • If YES, please answer these additional questions: o Do you have a new fever? YES_____NO _____ o Do you have a cough? YES_____NO _____ o Do you have diarrhea? YES_____NO _____ o Have you been vomiting? YES_____NO _____		
	Do you have any allergies to latex, medications, food, or any vaccine? **List:**_____		
	Are you allergic to chicken eggs or egg product?		
	Are you allergic to thimerosal (cleaning products or contact lens solution)?		
	Have you ever fainted or felt dizzy after receiving a vaccine?		
	Have you ever had a reaction after receiving a vaccine?		
	Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?		
	Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?		
	Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barré syndrome, or other nervous system problems?		
	For women: Are you pregnant or considering becoming pregnant in the next month?		
For Live Vaccines Only	Are you currently taking high-dose steroid therapy (prednisone >20 mg/day or equivalent) for longer than 2 weeks?		
	Are you currently on home infusions or weekly injections (such as Remicade, Humira, Enbrel, Cimzia, Simponi, Simponi Aria, Xeljanz, Orencia, Arava, Actemra, Cytoxan, Rituxan, adalimumab, infliximab, or etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs, or radiation treatments?		
	Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation?		
	During the past year have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?		
	Have you received any vaccinations or skin tests in the past 4 weeks?		
	For intranasal influenza: Do you have a long-term health problem such as heart, lung, kidney, liver, or metabolic disease (e.g., diabetes), asthma, neurologic or neuromuscular disease, or anemia or other blood disorder?		
	For intranasal influenza: Have you ever had a serious reaction to intranasal influenza vaccine (FluMist)?		
	For intranasal influenza: Are you older than age 49?		

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 are providing your primary care provider with records of the vaccine(s) administered here so that your medical records may be complete, but be sure to take your personal record with you to your next appointment as well.

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

I voluntarily request and consent that a pharmacist employed by Publix Super Markets, Inc. ("Publix") administer to me the vaccine(s) ("Vaccine") selected above. I acknowledge that Publix has given me a copy of the Vaccine Information Statement that contains information about the Vaccine including information on certain adverse reactions that I may experience as a result of receiving the Vaccine, and I have carefully read and understand the Vaccine Information Statement. I have had an opportunity to ask the Publix pharmacist any questions about the Vaccine or about information in the Vaccine Information Statement and my questions have been answered to my satisfaction. I have truthfully answered all the questions regarding my medical history that are listed above. I understand that if I answered a question with a "Yes" there is an increased likelihood that I will experience an adverse reaction from the administration of the Vaccine. After careful consideration, I believe that the benefits of receiving the Vaccine outweigh the risks associated with receiving the Vaccine and I have decided to have the Publix pharmacist administer the Vaccine to me. If applicable, I authorize Publix to submit a claim to my insurer for this healthcare service and authorize an assignment of my insurance benefits under such claim to Publix. 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 my insurance benefits. I authorize Publix to use and/or disclose such information about me, including any medical related information that I provide to Publix or that is created or received by Publix that Publix reasonably determines is necessary to receive payment for its services, carry out my treatment or conduct its healthcare operations. This authorization includes disclosures to regulatory agencies, Medicare, Medicaid, health plans, pharmacy benefit managers, claims processors, billing companies, interpreters and other persons involved in my treatment, as well as any state immunization registry. Publix shall not, at any time, or to any extent allowable by applicable law, be liable, responsible, or in any way be accountable for any loss, injury, death, or damage suffered or sustained by me or any other person at any time in connection with, or as a result of, the administration of the Vaccine to me by the Publix pharmacist. I, for myself,

my heirs, executors, personal representatives and assigns, hereby release Publix, its employees and contractors, specifically the administering pharmacist, its agents or representatives from any and all claims arising out of, in connection with, or in any way related to my receipt of the Vaccine from Publix as allowed by applicable law. By providing your mobile phone number, you expressly request and authorize us to deliver or cause to be delivered calls and unencrypted messages to you at the number provided, whether or not using an automatic telephone dialing system or an artificial or pre-recorded voice, for any and all purposes related to your treatment, including but not limited to prescriptions and reminders and information regarding completing the second dose of the vaccination, as well as related to payment, insurance, healthcare operations, quality improvement, utilization, disease or case management, or for telemarketing and advertising care alternatives and other benefits, products, and services that may be of interest. I understand that texts and push notifications are not secure. If others intercept the messages or access my 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. By signing below, I certify that I am the patient or the patient's guardian/personal representative signing on behalf of the patient, and that I have read, understand and agree to all the statements on this form.

Signature of Patient or Legal Guardian _____ Relation to Patient _____ Date _____

21174

For Publix Use Only:

Billing (select one): _____Medicare_____Cash_____Publix Associate_____Family Member_____Other (specify):_____)

Vaccine Administration Record

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

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
☐	☐

Printed Name of Pharmacist or Intern Administering Vaccine _____ Title _____ Pharmacist or Intern License # _____

Pharmacy Address _____ City, State, Zip _____

Pharmacy Phone # _____

Signature of Pharmacist Administering Vaccine or Signature of Pharmacist Supervising Pharmacy Intern _____ Drug Protocol # and Physician's Name _____

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: