CHEEK & SCOTT

Immunization Consent Form

Name: _____ Date of birth: _____ Age: _____ Social Security #: _____

Home address: _____ City/State/Zip: _____

Gender: _____ Phone: _____ Emergency Contact: _____ Phone: _____

Email address: _____ Doctor / primary care provider name: _____

Precautions and Contraindications: Please answer each question				
Vaccination Assessment	Do you have asthma, diabetes, smoke cigarettes or have heart, lung, kidney, or liver disease? (Pneumovax)	☐ Yes	☐ No	☐ Don't know
	Do you have asplenia, CSF leaks, or an immunocompromising condition (e.g. HIV/AIDS, cancer, leukemia, lymphoma, transplant, multiple myeloma, renal failure, nephrotic syndrome)? (Prevnar, Pneumovax, and 3rd COVID Dose)	☐ Yes	☐ No	☐ Don't know
	Are you taking any immunocompromising drugs (e.g. steroids or drugs for cancer, transplant, Crohn's, ulcerative colitis, psoriasis, rheumatoid arthritis, multiple sclerosis)? (Prevnar, Pneumovax, and 3rd COVID Dose)	☐ Yes	☐ No	☐ Don't know
	Are you at least 65 years old? (Prevnar and Pneumovax)	☐ Yes	☐ No	☐ Don't know
	Are you pregnant or in close contact with any newborn children? (Tdap – third trimester)	☐ Yes	☐ No	☐ Don't know
	Has it been more than 10 years since your last Tetanus shot? (Tdap)	☐ Yes	☐ No	☐ Don't know
	Are you at least 50 years old? (Shingrix)	☐ Yes	☐ No	☐ Don't know
	Do you plan to travel outside of the United States in the next year? (Online Travel Form)	☐ Yes	☐ No	☐ Don't know
Inactive and Live Vaccines	Have you had at any time in the last 10 days a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, diarrhea, or tested positive for COVID 19?	☐ Yes	☐ No	☐ Don't know
	Have you had COVID-19 Antibody therapy within the last 90 days (Regeneron, Convalescent Plasma)?	☐ Yes	☐ No	☐ Don't know
	Have you received a previous dose of any COVID-19 vaccine? If YES: What manufacturer? How many doses? Time since last dose?	☐ Yes	☐ No	☐ Don't know
	Have you ever had a seizure disorder, a brain disorder, Guillain-Barré syndrome or other nervous system problems?	☐ Yes	☐ No	☐ Don't know
	Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?	☐ Yes	☐ No	☐ Don't know
	Have you had a reaction after receiving an immunization? Do you have allergies to latex, medications, food or vaccines (e.g. eggs, gelatin, gentamicin, polymyxin, neomycin, phenol, or thimerosal)? If YES, list:	☐ Yes	☐ No	☐ Don't know
Live Vaccines Only	Do you have an immunocompromising condition or take an immunocompromising drug (see above)?	☐ Yes	☐ No	☐ Don't know
	Are you currently taking antivirals or high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than two weeks?	☐ Yes	☐ No	☐ Don't know
	Have you received any vaccinations or skin tests in the past 4 weeks?	☐ Yes	☐ No	☐ Don't know
	Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?	☐ Yes	☐ No	☐ Don't know
	For women: Are you pregnant or a chance you could become pregnant?	☐ Yes	☐ No	☐ Don't know
	Do you have a history of thymus disease (including myasthenia gravis), thymoma or prior thymectomy? (Yellow fever only)	☐ Yes	☐ No	☐ Don't know
	Are you currently taking any antibiotics or antimalarial medications? (Oral typhoid only)	☐ Yes	☐ No	☐ Don't know

I want to receive the following immunization(s): _____

Directions: Administer each immunization listed above as directed

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of Cheek and Scott Drugs, Inc., to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements or Emergency Use Authorizations on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering healthcare provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Cheek and Scott Drugs, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's immunization registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) Cheek and Scott Drugs, may disclose my immunization information to the State Registry, to the State HIE, or through the State HIE, to the State Registry, for purposes of public health reporting or to my health care providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, a Cheek and Scott Drugs opt-out form ("Opt-Out Form"): (a) the disclosure of my immunization information by Cheek and Scott Drugs to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my immunization information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. Cheek and Scott Drugs will, if my state permits, provide me with an Opt-Out Form upon request. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to Cheek and Scott Drugs reporting my immunization information to the State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide Cheek and Scott Drugs with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to Cheek and Scott Drugs and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information to or through the State HIE as required or permitted by law. I also authorize Cheek and Scott Drugs to disclose my, or my child's (or unemancipated minor for whom I am authorized to act as guardian or in loco parentis) proof of immunization to the school where I am, or my child (or unemancipated minor for whom I am authorized to act as guardian or in loco parentis) is, a student or prospective student. I further authorize Cheek and Scott Drugs to (a) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to, or through, the State HIE to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment, (b) submit a claim to my insurer for the above requested items and services, and (c) request payment of authorized benefits be made on my behalf to Cheek and Scott Drugs with respect to the above requested items and services. I further agree to be fully financially responsible for any cosharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if Cheek and Scott Drugs invoices me after the time of service, upon receipt of such invoice.

_____ _____ _____

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

For Pharmacy Personnel Only

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

_____ _____

Printed Name of Immunizer | Immunizer Signature

Per Immunization Protocol
Developed By Dr. A.C. Bass