Pharmacy

IMMUNIZATION CONSENT FORM

Name: _____ Birth date: _____ /____ /_____ Age: _____ Sex: M / F

Address: _____ City:_____ State: ____ Zip: _____

Phone: (_____) _____ Medicare ID # (including alpha): _____ Publix Associates only – Personnel # (if applicable): _____

Primary Care Physician Name: _____ Emergency Contact Name & Phone: _____

Which vaccine(s) would the patient like to receive today? **Select all that apply. State restrictions may apply.**

☐ COVID ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis Combo (A & B) ☐ HPV ☐ Influenza (Flu) ☐ Meningococcal
☐ MMR (Measles, Mumps & Rubella) ☐ Pneumococcal ☐ RSV ☐ Td/Tdap ☐ Zoster (Shingles) ☐ Others _____

	Precautions and Contraindications: Please mark YES or NO for each question.	**YES**	**NO**
For Inactive and Live	1. Are you 18 years of age or older? (Age restrictions may apply to certain states/vaccines. Consult the pharmacist.)		
	2. Do you have a cold, fever, or acute illness?		
	3. Do you have any allergies to medications, food, or any vaccine? **List:**_____		
	4. Are you allergic to chicken eggs or egg product?		
	5. Are you allergic to thimerosal (cleaning products or contact lens solution)?		
	6. Have you ever had a serious reaction after receiving a vaccination?		
	7. Have you ever been diagnosed with Guillain-Barré syndrome? *(for meningococcal)*		
	8. Do you have a seizure, brain, or nerve problem? *(for pertussis)*		
	9. Have you had a physical exam within the last year?		
For Live Vaccines Only	10. 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?		
	11. 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?		
	12. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?		
	13. For women: Are you pregnant/is there a chance you could become pregnant during the next month?		
	14. Have you received any vaccinations in the past 4 weeks?		
	15. For intranasal influenza: Do you have a long-term health problem such as heart, lung, kidney, liver, or metabolic disease (e.g., diabetes), neurologic or neuromuscular disease, or anemia or other blood disorder?		

If you answered YES to question 2–15, you must talk with your pharmacist before being vaccinated.

For purposes of this consent "I," "me," "my," and "you" 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. or any affiliate or subsidiary thereof (collectively, "Publix"). I hereby acknowledge that Publix has provided me with a Vaccine Information Statement, Emergency Use Authorization ("EUA"), or fact sheet ("Guidance") containing information about the Vaccine including information on certain adverse reactions that the Patient may experience as a result of receiving the Vaccine. I further acknowledge I have carefully read and understood this Guidance prior to the Patient's receipt of the Vaccine. I will ask the Publix Vaccine Provider or, if I prefer, the Publix pharmacist on duty if that pharmacist is not the Publix Vaccine Provider, any questions I may have about the Vaccine or about information in the Vaccine Information Statement prior to the Patient's receipt of the Vaccine. By allowing the Publix Vaccine Provider to 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 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 Publix Vaccine Provider to administer the Vaccine to the Patient.

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. 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, or that is created or received by Publix, 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, 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 applicable immunization registry, health information exchange, or adverse event database, or any designee, for public health reporting or care coordination. Depending upon applicable law, I may prevent the disclosure of certain vaccination information to the registry or exchange by completing an opt-out form that is available in the pharmacy. I understand that even if I do not consent or if I withdraw my consent, applicable law may permit certain disclosures of my vaccination information to or through the registry or exchange or to government agencies.

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 the Patient or me or any other person at any time in connection with, or as a result of, the administration of the Vaccine to the patient by the Publix Vaccine Provider. I, for myself and for the Patient, and for my and the Patient's heirs, executors, personal representatives, and assigns, hereby release Publix, and the employees and contractors (including specifically, without limitation, the administering Publix Vaccine Provider), as well as Publix's and its affiliates' and subsidiaries' agents and representatives from any and all claims arising out of, in connection with, or in any way related to the Patient's receipt of the Vaccine as and to the full extent allowed by applicable law.

By providing your mobile phone number or email, you expressly request and authorize Publix, to deliver or cause to be delivered calls and unencrypted messages to you at the number or email provided, by using an automatic telephone dialing system or an artificial or pre-recorded voice or other means, for any and all purposes related to the Patient's 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. 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.

By signing below, I certify that I have read, understood, and agreed to all the statements above and that either (a) I am the Patient, am at least 18 years old and do not have a guardian, or (b) I am the Patient's parent/guardian with authority to consent and agree on behalf of the Patient.

_____ _____ _____

Signature of Patient or Legal Guardian | Relation to Patient (if Patient) | Date

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 Physician Notification (Required in Georgia)

Notified physician	Patient does not have primary care physician—provided required paperwork
☐	☐

_____ _____ _____

Printed Name of Immunizer | Title | Pharmacist License #

_____ _____

Pharmacy Address | City, State, Zip

_____ _____ _____

Pharmacy Phone # | Signature of Pharmacist Administering the Vaccine or Supervising the Immunizer | Drug Protocol # and Physician's Name