Pharmacy

IMMUNIZATION CONSENT FORM – SOUTH CAROLINA

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 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: ○ Do you have a new fever? YES_____NO _____ ○ Do you have a cough? YES_____NO _____ ○ Do you have diarrhea? YES_____NO _____ ○ 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.

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. or any affiliate or subsidiary thereof (collectively, "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 the Patient's primary care provider to address ongoing medical issues and other types of preventive care. I understand Publix is providing the Patient's listed primary care provider with records of the vaccine(s) administered here so that the Patient's medical records may be complete, but will be sure to take the Patient's personal records to the Patient's next appointment as well.

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

I have read, or had explained to me, the Vaccine Information Statement, Emergency Use Authorization ("EUA"), 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 Publix Vaccine Provider to administer the Vaccine and communicate the administration of the Vaccine to the Patient's listed primary care provider. . I understand that EUA Vaccines are investigational and not FDA approved. This means it hasn't been fully tested by the FDA due to a public health emergency. I accept that no one involved in providing the EUA Vaccine (including the manufacturer, FDA, my doctor, or the person giving the shot) can be sued for any harm or loss I might suffer from getting it. This may include death, injury, fear of injury, property loss, or other damages.

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.

By allowing the Publix 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. 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 federal or state 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 us 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 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. 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 _____

RC1174

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 Immunizer _____ Title _____ Pharmacist or Intern License # _____

Pharmacy Address _____ City, State, Zip _____

Pharmacy Phone # _____

Signature of Pharmacist Administering the Vaccine or Supervising the Immunizer _____ 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 the Immunizer _____ Date _____

Place a copy of the prescription label here: