Vaccine Informed Consent Form

Patient Name: _____**Date of Birth**: _____/_____/_____

Address: _____**City**:_____**State**:_____**Zip**:_____

Gender: ☐ Female ☐ Male **Home Phone**: _____**Cell Phone**: _____

Physician Name: _____**City**:_____ **Phone No.**:_____

I want to receive the following immunization(s):

☐ Flu (Influenza) ☐ High Dose Flu (ages 65+) ☐ Pneumonia (pneumococcal) ☐ Shingles (Shingrix)

☐ Tdap (tetanus, diphtheria, pertussis) ☐ Td (tetanus, diphtheria)

☐ Hepatitis A ☐ Hepatitis B ☐ Meningococcal ACWY ☐ Meningococcal B

The following questions will help us determine if you should receive a vaccine today.
Please answer these questions by checking the boxes. If a question is not clear, please ask.

		Yes	No	Don't Know
1.	Are you sick today?	☐	☐	☐
2.	Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4.	Have you had a seizure, Guillain-Barre syndrome, brain or other nervous system problem?	☐	☐	☐
5.	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐

I agree that Big Y Pharmacy will notify my physician of vaccine received.
If applicable, I give Big Y Pharmacy permission to bill Medicare Part B on my behalf for vaccine.

RISKS AND POSSIBLE SIDE EFFECTS –Any vaccine may cause some side effects. The most commonly reported side effects may include soreness at the injection site and, with the flu vaccine, "mild" flu-like symptoms. Rare side effects may include allergic reaction and Guillain-Barre syndrome. If you experience unusual or severe symptoms after receiving any vaccination please contact your health care provider immediately.
I have received and read the vaccine information statement for vaccine(s) administered and explanations of possible adverse effects for the vaccinations and have had the opportunity to ask questions. I understand the benefits and risks of the vaccine and I consent to the administration of the vaccine. I acknowledge that I have been advised to remain near the vaccination location for approximately 20 minutes after administration for observation by the administering health care professional. Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators, and assignees, Big Y Foods, Inc. and their employees, owners, and representatives from any and all claims, demands, actions, and causes of action, which may result from participation in this program. I will communicate the information provided to me today about my vaccination to my primary care provider if I have one.

Signature _____ Date _____/_____/_____