PATIENT INFORMATION & CONSENT

Check the box by each vaccine requested. We accept Aetna, BCBS, Cigna, Humana & United Health plus Medicare B (flu only).

□ **Influenza Shot:** I am not allergic to eggs or egg products or thimerosal, do not have acute febrile illnesses (Fever>101º F) and have not had an anaphylactic reaction or developed Guillain-Barré syndrome after receiving a previous influenza vaccination. **VIS given: annual**

□ **HPV (Gardasil 9):** I have not had a reaction to any vaccine, am not pregnant, do not have acute febrile illness or a weakened immune system. **VIS given: 8/6/21**

□ **Hepatitis A:** I am not allergic to aluminum hydroxide, sodium borate and /or sodium chloride. **VIS given: 10/15/21**

□ **Hepatitis B:** I do not have multiple sclerosis and am not hypersensitive to yeast, formaldehyde, aluminum hydroxide or thimerosal. **VIS given: 5/12/23**

□ **Meningococcal: (Menquadfi)** I had no prior reaction to a tetanus toxoid-containing vaccine and am not pregnant. **VIS given: 8/6/21**

□ **Measles Mumps Rubella (MMR):** I have not had a reaction to a prior dose or any vaccine components, am not pregnant, do not have acute febrile illness or a weakened immune system. I have not had another live vaccine in last 4 weeks. **VIS given: 8/6/21**

□ **Pneumonia (Prevnar20):** I am over 50 and not pregnant or have a chronic health condition or is a child at risk. I have not had a dose of PPSV in the last 12 mos. I am not allergic to Diphtheria. **VIS given: 5/12/23**

□ **RSV (Arexvy/Abryso):** I am over 60, do not have a fever or severe illness and am have not had a prior allergic reaction to vaccines. **VIS given: 7/24/23**

□ **Tetanus, Diphtheria and Pertussis (TDAP)**: I am not allergic to aluminum phosphate, formaldehyde, glutaraldehyde, 2-phenoxyethanol or a prior DTaP Vaccine and have not had encephalopathy, or **progressive neurological disorder**. **VIS given: TDAP 8/6/21**

□ **Shingles (Shingrix):** I am at least 50 years old, not pregnant or breastfeeding, have not had a Zostavax vaccine within 8 weeks or a severe allergic reaction to any component of the vaccine (anaphylaxis) or after a previous dose of Shingrix. **VIS given: 2/4/22**

Patient Information Section-attach photocopy of insurance (front only) and driver's license

We don't accept- HMO plans other than BCBS TRS plans. We do not accept- BCBS prefixes: MQH, NCF, NKI, NUK,QHS, QQM, QSJ, RSK,UGD, UZF, VEL, XZA, YLA, ZGN, ZGZ & ZSA ZGP Groups: 000689,000748, 000940, 000955, 000956, 000301, 00700, 090047, 023530, 023535, 023540, 045636, 045637, 219319, Aetna Assurant SRC, Aetna Exxon, Cigna Local Plus, Freedom Life, United Navigate , Medicare Railroad or Any Bronze, Silver, Gold, Marketplace Plans.

Yes/ No Are you sick today or have you had a fever in the past 48 hours?
Yes/ No Are you pregnant or nursing?
Yes/ No Do you have any allergies? List all medicine or vaccine allergies_____
Yes/ No I am giving permission to the vaccinator to provide a copy of my vaccine record (consent) to my employer if requested.

_____/_____ Primary **Insured ID** **Group#**

_____ _____ _____ ___/___/___ ___ ___
Patient Last Name First Name Middle I Birth Date M/D/Y Age Sex

If same person, skip this line _____ _____ _____ ___/___/___ ___
Primary Insured Last Name First Name Middle I Birth Date M/D/Y Sex

_____ _____ _____ _____ _____ _____-_____-_____
Patient Address: Street City State County Zip Daytime Phone Number

_____ _____/_____-_____-_____
Signature of person receiving vaccine or Guardian Emergency Contact Person/ Emergency Phone #

E-mail:

If you have any questions, please ask now or check with your physician before receiving the vaccine. I understand the benefits and risks of these vaccinations and request those indicated above to be given to me. If you experience any significant reactions, see your physician. Please note that by signing this form you are accepting responsibility for all costs not covered by your insurance.

For Clinic Use Only below this point:

Vaccine Administered (nurse checks box by vaccine given)	**Lot #**	**Exp Date**	**Amount/Site**	**Injection Site**
Influenza Sanofi Fluzone ≥6mos ☐**MDV** ☐**Thim Free** ☐**High Dose>=65yr** **Seqirus Afluria** ≥6 mos ☐**MDV** ☐ **Thim Free** **Seqirus Flucelvax** ≥6mos ☐**MDV** ☐**Thim Free** **Seqirus Fluad** ≥65yr ☐**Thim Free** **GSK Fluarix Flulaval** ≥6mos ☐ **Thim Free**			**0.25ml ≤ 3yr IM Fluzone/Afluria 0.5 ml >6 mos IM for Flucelvax and Fluarix or >3 yr Fluzone/Afluria/ High Dose(.7),Fluad**	**Left Right**
HPV ☐ **Gardasil (Merck)** (9-14 or15-45yrs) 0, 6 to 12 mos or 0, 2, 6 mos			**0.5 ml IM**	**Left Right**
Hepatitis A ☐ **Havrix (GSK)** ☐ **Vaqta (Merck)**≥1yr 0, 6 months			**1.0 ml >18yr IM** **0.5 ml ≤18yr IM**	**Left Right**
Hepatitis B ☐ **Energix (GSK)** ☐ **Recombivax (Merck)** ☐ **Prehevbrio (VBI)** (18&up 1ml) all 0, 1, 6 mos			**1.0 ml > 19yr IM** **0.5 ml ≤19yr IM**	**Left Right**
Meningococcal ☐ **Menquadfi** (2yrs+)			**0.5 ml IM**	**Left Right**
MMR ☐ **MMRII(Merck)** born after 1957, (0,4wks)			**0.5 ml SC**	**Left Right**
Pneumonia ☐ **Prevnar20 (Pfizer)** for adults >50yrs or chronic health			**0.5 ml IM**	**Left Right**
RSV ☐ **AREXVY (GSK)** ☐ **ABRYSVO (PFIZER)** >60			**0.5 ml IM**	**Left Right**
TDAP ☐ **Boostrix (GSK)** 10+ ☐**Adacel(SP)**10y-64y, 1 every 5-10yr			**0.5 ml IM**	**Left Right**
Shingles ☐**Shingrix (GSK)** 0 & 2-6mos for adults>50 or chronic health			**0.5 ml IM**	**Left Right**

Nurse Signature: RN Date: Payment Amount: CASH CHECK# OTHER: INSUR BILL