

Flublok

Informed Consent for Immunization with Inactivated & Live Vaccines

Radichkova

Emma

J

04/25/2003

19

 M F Other

Last Name

First Name

Middle

Date of Birth

Age

Gender

109 Peach Terrace

Santa Cruz

CA

95060

(925) 639-8470

Home Address

City

State

Zip

Phone #

 Home Cell

Vaccine(s) requested: Flu
 COVID-19 Pneumonia
 Shingles Tetanus
 Other(s): _____

Ethnicity: Hispanic or Latino
 Non-Hispanic or Latino
 Decline to State (Unknown)

If less than 66
pounds list
weight: _____ Lbs.

Medicare Part B ID#: _____
Last 4 digits of SSN (Medicare patients only): _____
Email address: _____

Which arm do you prefer for
vaccine? Left Right

Race: Asian American Indian
 Pacific Islander Black or African American
 Caucasian Two or More Other

Primary Care Provider
Name: _____
Phone: _____ Address: _____

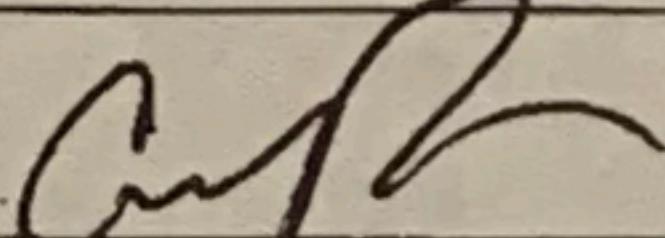
Screening Questions – IF COMPLETED ONLINE, REVIEW ANSWERS WITH PATIENT TO ENSURE NO CHANGES

		Yes	No
1.	Are you sick today?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	Do you have any allergies to medications, food or vaccines? If yes, please list: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	Have you ever had a serious reaction or fainted after receiving a vaccination?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	Do you have a medical condition or take medication(s) that may weaken your immune system? (e.g. cancer, leukemia, HIV, active shingles, take prednisone, oral steroids, anticancer or antiviral drugs)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	Have you ever received a dose of COVID-19 vaccine? (COVID-19 only) If yes, which product did you receive? <input checked="" type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> J&J Date(s): 05/05/2021 05/20/2021	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	For women: Are you pregnant or are you considering becoming pregnant in the next month?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	Do you have a seizure disorder or a brain disorder? (Tdap only)	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Immunization Needs

		Yes	No	Unsure
8.	Please check all that apply to you: <input type="checkbox"/> Asthma or lung disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Tobacco Smoker <input type="checkbox"/> 65 Years or older. If you checked any of the above, have you ever received a PNEUMONIA vaccine? If yes, when and what kind(s)? _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9.	Patients 50 and older or immunocompromised: Have you ever received the SHINGLES vaccine? If so, what date(s): _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10.	How many years has it been since your last TETANUS vaccine?	2	yrs	<input type="checkbox"/>
11.	Patients 19 to 59 years old: Have you received a hepatitis B series?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Patients under 46: Have you received the HPV (Human Papillomavirus) vaccine?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Patients aged 11 to 23: Have you received a meningitis vaccine?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Please indicate which vaccine(s) you would like more information about? <input type="checkbox"/> Hepatitis A <input type="checkbox"/> MMR (Measles, Mumps, Rubella) <input type="checkbox"/> Travel Vaccines <input type="checkbox"/> Childhood Vaccines N/A <input type="checkbox"/> Other: <input type="checkbox"/> Unsure: would like an assessment done of potential vaccination gaps or needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Yes	No
15.	Have you received any vaccination in the past 4 weeks? If yes, please list: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
16.	During the past year, have you received a transfusion of blood or blood products, been given a medicine called immune (gamma) globulin, or had radiation therapy?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
17.	Have you had your thymus gland removed or a history of problems with your thymus such as myasthenia gravis, DiGeorge syndrome, or thymoma? (yellow fever only)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
18.	Are you currently taking any antibiotics or antimalarial medications? (oral typhoid only)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
19.	Do you have a history of thrombocytopenia or thrombocytopenia purpura? (MMR® II only)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
20.	For age under 18: Are you taking aspirin or an aspirin containing medication? (intranasal flu only)	<input type="checkbox"/>	<input checked="" type="checkbox"/>

x 

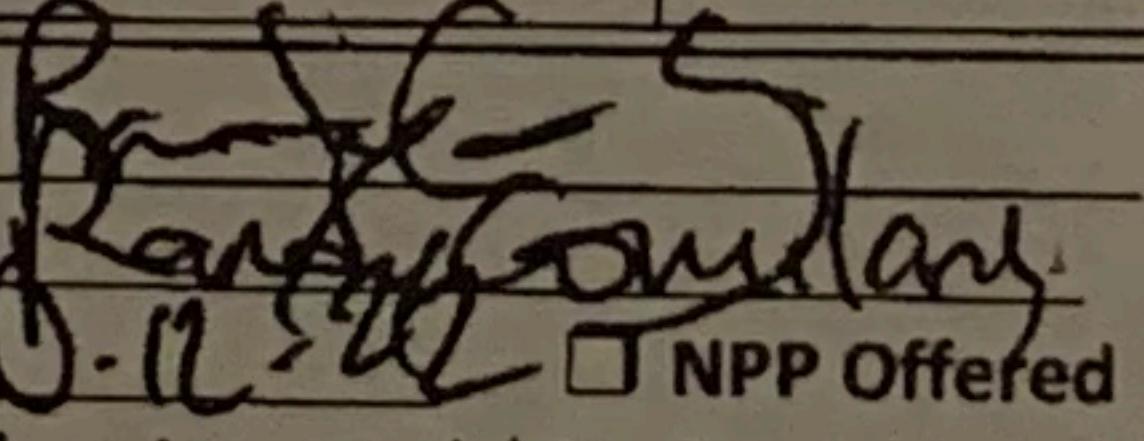
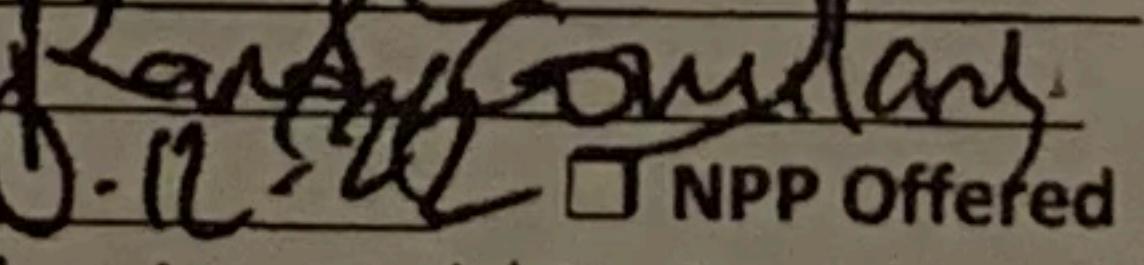
Signature of Patient or Parent/Guardian of Minor Patient

Emma Radichkova
Printed Name

Date 10/12/2022

For Pharmacy Use Only

Vaccine Name	Lot #	Expiration Date	Manufacturer	Dose (ml)	Dose #	Route	Site (circle)	VIS/EUA Pub. Date
COVID-19()					# _____	IM	R / L Deltoid	
Flu ()	FLUBLOK® Quadrivalent NDC 49281-722-08 Lot: QFAA2207 Exp.:16Jun2023			0.5		IM	R / L Deltoid	
Shingrix®			GSK	0.5	<input type="checkbox"/> 1 <input type="checkbox"/> 2	IM	R / L Deltoid	2/4/2022
Prevnar 20®			Pfizer	0.5	1	IM	R / L Deltoid	2/4/2022
						R / L		
						R / L		

Ordering RPh Signature: Name of Administrator: 

Administration Date: 10-12-22

NPP Offered

Counseling (Please circle): Accepted / Declined

RxBIN: 003858
PCN: AU Group #: AMAZON1 ID#: W251995941
Medical (Name, ID#, Group#, Payer ID - if UHC):
Billing Info (off-site only)
Clinic Name: Clinic Address: per 100 ft #3

WA ONLY: Substitution Permitted: _____

Dispense as Written: _____

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