________Current Temperature

Vaccine Consent Form

First Name:___________________Middle:___________________Last Name:__________________Date of Birth:___/___/_____

Address:___________________________City:__________________________State:___________________Zip:_______________

Phone: (____)____________Primary Care Physician:________Vaccine:______Occupation: ____________

Medicare Part B: Yes/No Medicare ID Number (From Red, White & Blue Paper Card):________________________ Sex: ☐ M☐F

Prescription Insurance Cardholder ID:______________________BIN_______________PCN_____________Group__________

Race: ☐ Asian ☐ Black ☐ American Indian ☐ White ☐ Other SSN : _______________________________________

Please answer the following questions to determine if you are eligible for a vaccine. If you have any questions, please ask a pharmacist.

	Vaccine Questionnaire	Yes	No
1	Are you currently sick with a moderate to high fever, vomiting/diarrhea?		
2	Have you ever had a serious reaction after receiving an immunization including feeling dizzy or fainting?		
3	Do you have chronic health conditions such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorder?		
4	Do you have cancer, leukemia, HIV/AIDS or any other immune system problem? Have you been diagnosedwith rheumatoid arthritis, ankylosing spondylitis, Crohn's disease?		
5	Do you have allergies to latex, medications, food or vaccines? (eggs, gelatin, neomycin, polymixin or thimerosal, polyethylene glycol). If yes, please list ___________________		
6	Have you ever had a seizure disorder, brain disorder (including Guillian Barre) or any other nervous system disorders?		
7	In the past 3 months have you taken medications that weaken the immune system such as cortisone, prednisone, other steroids or anticancer drugs, or have you had radiation treatments?		
8	**For Tdap and adult Td (ONLY):** Do you have an open wound, puncture or tissue tear that prompted you to get a tetanus shot?		
	For women: are you pregnant or considering becoming pregnant in the next month?		
	Live Vaccines Only		
1	Are you currently on home infusions or weekly injections?		
2	Have you received any vaccines or skin tests in the past four weeks?		
3	Have you received a blood transfusion, blood products, or immune globulin or antiviral drug in the past year?		
4	Do you have a history of thymus disease or thymectomy? (yellow fever only)		
5	Are you currently taking any antibiotics or antimalarial medications? (Oral typhoidonly)		

If receiving a booster or additional dose of the COVID-19 vaccine, outside of the primary series, I attest that I meet the current CDC requirements. I certify that I am: (i) the Patient and at least 18 years of age; (ii) the parent or legal guardian of the minor Patient; or (iii) the legal guardian of the Patient. Further, I hereby give my consent to the healthcare provider of SEG pharmacies. I acknowledge that I have received, read and understand the Vaccine information Statement for the vaccines(s) below. I have had the chance to ask questions about the contents of the Vaccine Information Statement. I understand both the benefits and risks associated with receiving this vaccine and believe the benefits outweigh the risks. I understand and agree that this company may be required by applicable law to report certain information without notice to me about my vaccinations to the appropriate state and federal regulatory authorities for purposed such as reporting of adverse events or immunization registries. I further agree to hold harmless BI-LO, LLC and its subsidiaries, officers, employees, agents, representatives, contractors, successors and assignees from any claim or action arising out of or, in any way incidental to this vaccination. I am under no duress, and have read and understand this informed consent for the vaccine listed below. I will communicate the information provided to me today about my vaccination to my primary care provider if I have one. I also understand that i should wait in store for a 15-minute observation period after receiving my vaccine. Additionally, by signing below I attest that I qualify to receive vaccine based on my state health jurisdictions guidelines/eligibility requirements.

______________________________ ____ _______________

Print Name Signature of Patient of Legal Guardian Date

Admin Date	Vaccine	Lot #	Exp Date	Manufacturer	Dosage	Site of Injection	EUA Date	VIS Date	Date MD Notified

For children ages 3-17: I attest I informed the patient or adult caregiver of the importance of pediatrician wellness checks ☐

Signature of administering Pharmacist:

Last edited on: 9/24/2021