

UTAH IMMUNIZATION INFORMED CONSENT

updated 4-23-20

\_\_\_\_\_  
 First Name MI Last Name

\_\_\_\_\_  
 Home Phone Date of Birth (mm/dd/yyyy) Age M F  
 Gender

\_\_\_\_\_  
 Home Address City State Zip Code

The following questions will help us determine your eligibility to be vaccinated today.		Yes	No	Don't Know
1.	Do you have a fever or illness today?	___	___	___
2.	Have you experienced any of the following in the past 14 days: fever, unusual cough, unusual shortness of breath?	___	___	___
3.	Have you or a household contact been diagnosed with COVID-19 in the past 14 days?	___	___	___
4.	Do you have allergies to medications, food (e.g. eggs), latex, or a vaccine component (e.g. bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol or thimerosal)? If yes, please list the allergies _____	___	___	___
5.	Have you received any vaccinations or skin tests in the past 28 days? If yes, please list the vaccination. _____	___	___	___
6.	Have you ever had a serious reaction to an influenza vaccine or any other vaccine in the past?	___	___	___
7.	Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem?	___	___	___
8.	Are you 65 years of age or older?	___	___	___
9.	Do you smoke?	___	___	___
10.	Do you have a chronic condition or long-term health problem? <b>If yes, please check all that apply.</b> ___ Anemia ___ Asthma ___ Diabetes ___ Heart disease ___ Kidney disease ___ Liver disease ___ Lung disease ___ Other	___	___	___
11.	If you answered YES to question #6, 7 or 8, have you ever had a pneumonia vaccination?	___	___	___
12.	Have you ever had a shingles vaccination (for patients 50 years of age and older only)?	___	___	___
13.	<b>For women:</b> Are you pregnant or considering becoming pregnant in the next month?	___	___	___
LIVE VACCINES	14. For the past 3 months, have you taken medications that affect your immune system, such as prednisone or other steroids, anti-cancer drugs, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis; or have you had radiation treatments?	___	___	___
	15. Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or are you in contact with anyone who has a severely weakened immune system?	___	___	___
	16. Have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?	___	___	___
	17. Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)	___	___	___
	18. If the patient receiving vaccine is under 5 years old, is there a history of asthma or wheezing? (for FluMist® only)	___	___	___
	19. Does the patient have a nasal condition serious enough to make breathing difficult, such as a very stuffy nose? (for FluMist® only)	___	___	___

I have received a Notice of Privacy Practice for HIPAA. I have read, or have had read to me, the Vaccine Information Statement (VIS) referred to above. I have been able to ask questions about the vaccine(s), and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to the administration of the vaccine(s) requested. I authorize the information to be forwarded to my physician, the authorizing physician, Utah State Immunization Information System (USIIS), or the local Dept. of Health, if applicable. **I agree to stay in the general area for 15 minutes** after receiving my vaccination in case any immediate reactions occur. If I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); the subsidiaries and affiliates of the pharmacy; the respective directors, officers, employees, and agents of the pharmacy and its subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability that might arise from this vaccination.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Parent or Guardian, if minor)

**Vaccines Provided Today:**

- Influenza Quadrivalent  
  Influenza Adjuvanted (65+)  
  Influenza High Dose (65+)  
  Influenza Recombinant (FluBlok)  
 Influenza Cell-Based (Flucelvax)  
  LAIV (FluMist)  
  Hepatitis A  
  Hepatitis B  
  Hepatitis A/B (Twinrix)  
  HPV-9  
 Pneumococcal PSV23  
  Pneumococcal PCV13  
  Men ACWY  
  Men B  
  Shingles  
  Tdap  
  Other: \_\_\_\_\_

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<div style="border: 1px dashed gray; padding: 5px; margin-bottom: 5px;">Apply vaccine label here</div> vaccine, lot, exp date, manufacturer, dose (ml)	Route _____ Right or Left Arm _____ Admin. Date _____ Admin. Site _____ VIS Date (on form) _____
Administrator*	Administrator*

By signing as administrator you confirm that contraindications and side effects have been reviewed and a current VIS provided to the patient receiving the vaccine.