Informed Consent for Immunization

❒ M ❒ F

Last Name | **First Name** | **Middle** | **Date of Birth** | **Age** | **Sex Assigned at Birth**

Home Address | **City** | **State** | **Zip** | **Phone #** ( ) - ❒ **Home** ❒ **Mobile**

If less than 66 pounds list weight: _____ Lbs.

Vaccine(s) requested: ❒ Flu ❒ COVID ❒ RSV ❒ Shingles ❒ Pneumonia ❒ HPV ❒ Tetanus/Whooping Cough ❒ Hepatitis B ❒ Hepatitis A ❒ Meningitis ❒ MMR ❒ Other: _____

Ethnicity: ❒ Hispanic or Latino ❒ Non-Hispanic or Latino ❒ Decline to State

Race: ❒ Asian ❒ American Indian or Alaska Native ❒ Native Hawaiian or Pacific Islander ❒ Caucasian ❒ Black or African American ❒ Middle Eastern or North African ❒ Two or More ❒ Other

Which arm do you prefer for vaccine? ❒ Left ❒ Right

Primary Care Provider Name: _____

Phone: _____ Address: _____

Medicare patients only: Last 4 digits of SSN: _____

Medicare Part B ID#: _____

	Screening Questions	Yes	No
1.	Are you sick today?	❒	❒
2.	Do you have any allergies to medications, food or vaccines? If yes, please list: _____	❒	❒
3.	Have you ever had a serious reaction or fainted after receiving a vaccination (e.g. Guillain-Barré Syndrome)?	❒	❒
4.	For women: Are you pregnant, breastfeeding or are you considering becoming pregnant in the next month? If pregnant, gestational week: _____	❒	❒
5.	Check all that apply to you: ❒ Seizure disorder/brain disorder ❒ Thymus gland removed or problems with your thymus such as myasthenia gravis, DiGeorge syndrome, or thymoma? (yellow fever only) ❒ Currently taking antibiotics or antimalarial medications? (oral typhoid only) ❒ Hospice ❒ Asplenia ❒ Weakened immune system (e.g. cancer, HIV, active shingles, oral steroids, anticancer or antiviral drugs, blood transfusion or products, immune globulin, radiation therapy) ❒ History of thrombocytopenia or thrombocytopenia purpura? (MMR®II only) ❒ Received any vaccination in the past 4 weeks? If yes, please list: _____		

I hereby attest to the following: (1) I am of legal age and authorized to execute this consent form on behalf of myself or the individual receiving the vaccine(s); (2) I voluntarily consent to the administration of the vaccine(s) by an individual legally authorized to administer vaccines who is either employed or contracted by Albertsons Companies, Inc. or one of its affiliated pharmacies ("ACI"); (3) the information I have provided in this form is correct and I, or the person for whom I am consenting, meet eligibility criteria for the vaccine(s); (4) I have been offered and/or provided a copy of the company's Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act ("HIPAA"); (5) I have received, read and/or had explained to me the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization(s) ("EUA") for the vaccine(s) to be administered; (6) I understand the risks and benefits of the vaccine(s), including recommended timing for receiving such vaccine(s) and possible side effects; and (7) I have had the opportunity to ask questions and they have been answered to my satisfaction. I understand that I must alert the pharmacist of any medical condition(s) which may impact my ability to safely receive the vaccine(s). I acknowledge that I have been advised to remain in the area for observation for 15 minutes after vaccination, or if there is any history of an allergic reaction of any severity to a vaccine or injectable therapy or of anaphylaxis due to any cause, to remain in the area for 30 minutes after vaccination. I understand that if I leave the area without waiting, I am doing so at my own risk and against medical advice. If an adverse event occurs, I consent to the administration of emergency measures deemed necessary, including administration of epinephrine. On behalf of myself or the patient their heirs and personal representatives, I release ACI and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting from, in connection with, or in any way related to the administration of the vaccine(s). I authorize ACI to submit a claim for reimbursement on my behalf to Medicare, Medicaid, or a third-party payor, including my employer if they are paying for the vaccine(s). If the claim is denied, I agree to be responsible for payment. I acknowledge this vaccination may be subject to reporting to my state's immunization registry or health department and subsequent sharing with other healthcare providers. Depending on my state laws, I understand that I may be able to opt out of such reporting by following the requirements set by my state, including notifying ACI of my preference where applicable. If my state requires express consent for such data sharing, my signature below evidences my consent unless I have expressly indicated otherwise to ACI. (New Jersey only: I authorize ___ do not authorize ___ reporting of my receipt of this vaccination to my primary care provider; failure to check authorize/do not authorize will serve as authorization.) For parents/guardians of minor patients, I confirm I have received written notice to visit a pediatrician annually. By signing below, I acknowledge and agree with the above statements and give my consent for vaccination.

Immunization Needs: Please check all that apply to you. (Eligibility may depend on immunization history, risk factors or gestational week if pregnant.)

Date of last: Flu vaccine 1/25/2026 **COVID-19 vaccine** _____ **TETANUS (Td or Tdap) vaccine:** _____

Based on the disease state below,	you may be eligible to receive (ages 18 and older):						
❒ Diabetes	Flu	COVID	Pneumonia	Shingles	Hepatitis B	Tdap	RSV
❒ Heart Disease							
❒ Asthma/lung disease							
❒ Immunocompromised							
❒ Liver or kidney disease (dialysis)							
❒ Tobacco smoker							N/A
❒ Pregnancy		Tdap (weeks 27-36)			RSV(Abrysvo only; weeks 32-36 from September through January)		

Based on your age below,	you may be eligible to receive:					
❒ Age 50 or older	Flu	Pneumonia	Shingles	Hepatitis B	Tdap	RSV(75+ or based on risk)
❒ Age 18-49		Hepatitis B	Tdap	HPV(max age: 45)	Meningococcal B (age 16-23)	
❒ Age 11-17		Tdap	HPV	Meningococcal ACWY (age 11-16) or Meningococcal B (age 16-23)		

X _____ _____ _____

Signature of Patient or Parent/Guardian of Minor Patient (include relationship to minor) | Printed Name | Date

I acknowledge and agree that ACI makes no representation or guarantee regarding reimbursement from any third-party payer. I understand that I am fully responsible for all charges that are not reimbursed. X____Initial

Reminder: Collect Patient Insurance and either scan or document BIN, PCN, Rx Group, ID number, & any medical billing details if applicable on back of this form

Vaccine Name	Lot #	Expiration Date	Manufacturer	Dose (ml)	Dose #	Route	Site (circle)	VIS/EUA Pub. Date
Flu (_____)				0.5	N/A	IM	R / L Deltoid	
COVID-19 (_____)					N/A	IM	R / L Deltoid	
						IM	R / L _____	
							R / L _____	
							R / L _____	

INTERNAL USE

Ordering RPh Signature: _____ Name of Administrator: _____ Admin/VIS Provided Date: _____ ❒ NPP Offered

Counseling (Please circle): Accepted / Declined ❒ Offsite Clinic Clinic Name: _____ Clinic Address: _____

Appt Date: _____ Appt Time: _____ Administration time (OR Only): _____ WA ONLY: Substitution Permitted _____ Dispense as Written: _____