VACCINE ADMINISTRATION CONSENT FORM

Quality Plus Pharmacy

SECTION A – INFORMATION ABOUT THE PERSON RECEIVING THE VACCINE

Name: Date of Birth: / / Phone: ( )

Address: City: Zip Code:

Insurance Carrier Name: ID #: Group #:

Policy Holder Name (if different): Policy Holder Date of Birth:

Vaccines Needed: Flu Pneumonia Shingles Td Tdap Hepatitis A Hepatitis B Meningitis HPV Other:

Primary Care Provider Name: Phone: ( ) Fax: ( )

SECTION 2 – QUESTIONS TO DETERMINE VACCINE ELIGIBILITY (Circle YES OR No)

1. In the last 10 days, have you or someone with whom you've been in close contact been diagnosed with COVID-19?	YES	NO
2. Are you sick today or do you have any of these symptoms: fever, chills, shortness of breath, body aches, loss of taste/smell	YES	NO
3. Do you have any long-term health conditions? *(ex: heart disease, diabetes, asthma, COPD, kidney disease, anemia)*	YES	NO
4. Do you have allergies to medications, foods, or latex? *(ex: egg, bovine, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast)*	YES	NO
5. Have you had any serious reactions from a vaccine?	YES	NO
6. Are you taking biological injectables, steroids, anticancer drugs, antivirals, or have you had recent radiation treatments?	YES	NO
7. Do you have a seizure disorder, brain disorder, Guillain-Barre Syndrome, or nervous system disorder?	YES	NO
8. Do you have a problem with your immune system, history of AIDS, bone marrow disease or tuberculosis?	YES	NO
9. During the past year, have you received blood or blood products or been given immune (gamma) globulin?	YES	NO
10. Have you had any vaccinations in the past 4 weeks?	YES	NO
11. Are you age 65 years or older? Age:	YES	NO
12. FOR WOMEN: Are you pregnant, or is there a chance you could become pregnant in the next month?	YES	NO

SECTION 3 – PLEASE READ CAREFULLY AND ACKNOWLEDGE WHERE APPROPRIATE

I hereby give my consent to Quality Plus Pharmacy (QPP) to administer the vaccine(s) (the "Services") I have requested below. Legal effective July 22, 2016

With my Initials, I certify that:

I am: (i) the Patient and at least **18** years of age; (u) the parent or guardian of the minor Patient; or (iii) the legal guardian of the Patient; or (iv) a person authorized under the law of another state or a court order to consent for the child, OR

The persons identified under (ii), (Iii), or (ivl, in the preceding sentence are unavailable and I have authority to consent to the immunization of the child because I am a (i) grandparent; (ii) adult brother or sister; (Hi) adult aunt or uncle; (iv) stepparent; or (v) another adult who has actual care, control, and possession of the child and has written authorization to consent for the child from a parent, managing conservator, guardian, or other person who, under the law of another state or a court order, may consent for the child; additionally, I certify that I do not have knowledge of any express refusals or withdrawn authorizations of consent and have not been told not to give consent for the child.

I understand that any Protected Health Information ("PHI") I provide QPP will only be used or disclosed by QPP in accordance with QPP's Health Insurance Portability and Accountability Act ("HIPAA") Notice of Privacy Practices. By signing below, I acknowledge receipt of such HIPAA Notices of Privacy Practices and consent to the uses and disclosures of PHI described therein. While **QPP** reserves the right to not do so, I consent to **QPP** reporting my immunization information to the State Immunization Registry. Should QPP elect to report my immunization history to the Michigan central immunization registry, mcir.org, I further understand that my immunization information may be accessed by other health care providers, educators, public health representatives, state agencies and certain insurance payers. I further authorize QPP, to (1) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment or otherwise, (2) submit a claim to my insurer for the below requested items and services, and (3) request payment of authorized benefits be made on my behalf to QPP with respect to the below requested items and services. I further agree to be fully financially responsible for any co-sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if QPP invoices me after the time of service, upon receipt of such invoice. Please note for non-prescription insurance (i.e. medical/health insurance), your insurance will notify you and QPP the exact copay/coinsurance amount due once they receive and process the claim. You may receive an invoice for any amounts due, up to and including the total amount of the claim.

NOT A SUBSTITUTE FOR A PHYSICIAN

I understand that QPP Pharmacy representatives are not physicians trained to diagnose and treat medical problems. I acknowledge that the administration of Services does not constitute, and should not be interpreted as, medical advice or opinions substituting for the advice of a physician. I understand that the administration of Services does not create a doctor-patient relationship between myself and QPP. I agree to consult a physician if I require medical advice or services at any time.

RELEASE, IMDEMNITY AND DISCLAIMER

I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the below vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I additionally acknowledge that I have received a copy of the QPP Pharmacy notice of privacy. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering health care provider. I understand that during the requested vaccine administration, an QPP Pharmacy representative could possibly be exposed to my blood or bodily fluids. In such event, I agree to review and execute the "QPP Post-exposure Consent for Testing" form.

On behalf of myself, my heirs and personal representatives, I further hereby WAIVE, RELEASE, and AGREE TO INDEMNIFY, DEFEND AND HOLD HARMLESS (including for costs and attorney's fees) QPP, its staff, agents, employees and corporate affiliates from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of Services listed below, even should such damages or losses result from QPP's negligence.

Patient Signature: **Date:**

(Parent or Legal Guardian, if minor)

SECTION 4 — PART B O N L Y

Medicare Part B Authorization Form

Statement to Permit Assignment of Medicare Benefits

- I understand that I am giving **Quality Plus Pharmacy** permission to ask for Medicare payments for my medical care, including supplies and equipment.
- I understand that Medicare needs information about me and my medical condition to decide about these payments. I give permission for that information to go to Medicare and the companies that handle Medicare payment requests.
- I understand that the Centers for Medicare & Medicaid Services (CMS) is the government's Medicare agency. I understand that a photocopy of this release is as valid as the original document. Furthermore, I understand that I am responsible for paying any deductible or coinsurance amounts.
- Therefore, I ask that payment of authorized Medicare benefits be made to either me or on my behalf to **Quality Plus Pharmacy** for any services or items furnished to me by **Quality Plus Pharmacy. I** authorize any holder of medical or other information about me to release such information to the Centers for Medicare & Medicaid Services (CMS) and its agents as needed to determine these benefits or benefits for related services.

Name _____ HICN: _____

Signature: _____ Date:_____

SECTION 5 PHARMACY USE ONLY Temperature checked by (partner initials): _____

Vaccine	Brand Name	Amount Administered	Manufacturer	Route	Lot Number	Site of Administration*
Inactivated Influenza	Fluzone HD	0.7 ml	Sanofi Pasteur	I M		RD LD
Inactivated Influenza	Flublok	0.5 ml	Sanofi Pasteur	I M		RD LD
Inactivated Influenza	Fluad	0.5 ml	Seqirus	I M		RD LD
Inactivated Influenza	Flucelvax Quad	0.5 ml	Seqirus	I M		RD LD
Inactivated Influenza	Afluria Quad	0.5 ml	Seqirus	I M		RD LD
Inactivated Influenza	Fluarix Quad	0.5 ml	GSK	I M		RD LD
Inactivated Influenza	Flulaval Quad	0.5 ml	GSK	I M		RD LD
Inactivated Influenza	Fluzone Quad	0.5 ml	Sanofi Pasteur	I M		RD LD
Hepatitis A	Havrix	0.5 ml/ 1 ml	GSK	I M		RD LD
Hepatitis B	Heplisav	0.5 ml	Dynavax	I M		RD LD
Hepatitis B	Engerix	0.5 ml/ 1 ml	GSK	I M		RD LD
Hepatitis A/B	Twinrix	1 ml	GSK	I M		RD LD
Herpes Zoster (shingles)	Shingrix	0.5 ml	GSK	I M		RD LD
HPV-9	Gardasil 9	0.5 ml	Merck	I M		RD LD
Meningococcal (ACWY)	Menveo	0.5 ml	GSK	I M		RD LD
Measles/Mumps/Rubella	MMR II	0.5 ml	Merck	S C		RA LA
Pneumococcal-23	Pneumovax	0.5 ml	Merck	I M / S C		RD/RA LD/LA
Pneumococcal-13	23	0.5 ml	Pfizer	I M		RD LD
Td (tetanus/diphtheria)	Prevnar 13	0.5 ml	Sanofi Pasteur	I M		RD LD
Td (tetanus/diphtheria)	Tenivac	0.5 ml	Grifols	I M		RD LD
Tdap (tet/dip/pertussis)	Tet/Dip	0.5 ml	GSK	I M		RD LD
Typhoid	Boostrix	0.5 ml	Sanofi Pasteur	I M		RD LD
Typhoid	Typhim	4 caps	PaxVax	O r a l		By Mouth
Varicella (chicken pox)	Vivotif	0.5 ml	Merck	S c		RA LA
Other						

' R D - Right Deltoid, LD Left Deltoid, RA - Right Arm, LA - Le ft Arm

Vaccine Information Sheets

Influenza (inactive/live) - 8/15/19
Pneumococcal PP5V23 - 10/30/19
Pneumococcal PCV13 - 10/30/19
Hepatitis A - 7/28/20
Hepatitis B - 8/15/19
Herpes Zoster - 10/30/19
HPV - 10/30/19
Meningococcal ACWY - 8/15/19
Meningococcal B-8/15/19
Japanese Encephalitis - 8/15/19
MMR - 8/15/19
Td - 4/1/20
Tdap - 4/1/20
Varicella - 8/15/19
DTap - 4/1/20
Hib - 10/30/19
Polio - 10/30/19
Rabies - 1/8/20
Typhoid - 10/30/19
Cholera - 10/30/19

To be completed by immunizer

Pharmacist Initials: _____

Signature: _____

Date of Immunization: _____

QUALITY PLUS PHARMACY

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