United supermarkets Amigos Albertsons market Market STREET **UNITED PHARMACY CLINICAL SERVICES** United supermarkets Amigos Albertsons market Market STREET

IMMUNIZATION CONSENT

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F

Address: _____ Phone #:(____)_____ Primary Physician (If known) _____

MEDICARE RECIPIENTS: (We will need a copy of your card)
Do you have a Medicare Advantage plan? ☐ Yes ☐ No

UNITED FAMILY TEAM MEMBER #: _____
Store or Location: _____ Are you a dependent?: ☐ Y ☐ N

Flu: ☐ Quadrivalent (4 strain) ☐ Trivalent (3 strain) ☐ High Dose (65+) ☐ Flublok (preservative/egg free extra protection)

Older Adults: ☐ Prevnar 13 ☐ Pneumovax 23 ☐ Shingles

Adolescents and young Adults: ☐ HPV ☐ Meningitis (MCV4) ☐ Meningitis B

Routine: ☐ Td (tetanus) ☐ Hep A ☐ Hep B ☐ Hep A & B ☐ MMR ☐ Varicella ☐ Polio ☐ Rabies

Families with babies or contact with young children: ☐ Tdap (whooping cough)

Travel: ☐ Yellow Fever ☐ Typhoid (oral) ☐ Typhoid (shot) ☐ Japanese Encephalitis ☐ Cholera

Work: ☐ TB skin test ☐ **Other:** _____

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE:

☐ Yes ☐ No Have you ever had an allergy or serious reaction to latex, eggs, vaccines or any medications?
If yes please specify allergy or reaction: _____

☐ Yes ☐ No Do you have any long term heath conditions or smoke? Please list conditions: _____

☐ Yes ☐ No Do you weigh less than 66 lbs?

☐ Yes ☐ No If you are diabetic, have you received the hepatitis B series of vaccinations?

☐ Yes ☐ No ***For WOMEN:*** Are you currently breastfeeding, pregnant or planning to become pregnant in the next month?

☐ Yes ☐ No If you are over 65 years of age have you received ***BOTH*** pneumonia vaccines?

☐ Yes ☐ No If you are over 60 years of age have you received a shingles vaccine?

☐ Yes ☐ No Have you had any ***LIVE*** vaccinations in the past 4 weeks? (ex: MMR, Varicella, Shingles, FluMist or Yellow Fever)

☐ Yes ☐ No Have you taken an antiviral medication within the past 48 hours? (i.e. Tamiflu, Valtrex, Famvir, acyclovir)

☐ Yes ☐ No Are your currently taking any medications that may thin the blood and increase bleeding?

☐ Yes ☐ No Have you experienced a fever (>100.5), nausea, vomiting or diarrhea within the past 24 hours?

☐ Yes ☐ No Are you currently taking steroid therapy, chemotherapy, radiation treatments, or medications for rheumatoid arthritis?

I verify I have answered the questions above accurately and to the best of my knowledge. I have been provided access to a copy of United Supermarket Pharmacy's Notice of Privacy Practices & the Vaccine Information Statement for the vaccine(s) I will receive today. I understand the benefits and risks of receiving this immunization, and have been given the opportunity to ask any questions. I hereby release United Supermarkets, LLC, and all officers, directors and employees from any and all liability arising from or in any way connected with this immunization. I understand that my receipt of this vaccination is subject to reporting, by my pharmacy or its business associate, to an immunization registry, which may share my immunization data with others, and to my primary care physician, the authorizing physician, or the local Dept. of Health, if applicable, and I authorize these disclosures. I hereby request that the above named immunization(s) be given to me or to the person named above for whom I am authorized to sign.

Signature _____ Date _____

PLACE Rx LABEL HERE

CLINIC: _____ PRICE MODIFY: ☐ Y ☐ N

FOR PHARMACY USE ONLY

Medicare #:

PAID: $ ☐ Cash ☐ Credit ☐ Account

Vaccine	Lot	Exp	Site	VIS DATE
1st:			R/L	
2nd:			R/L	
3rd:			R/L	
4th:			R/L	
5th:				

Administered by: _____

Revised 8/2015 SW