COMMUNITY HEALTH ALLIANCE

Vaccine Informed Consent

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____

Age: _____

Street: _____

City: _____ Zip Code: _____ Phone: _____ **Circle one**: Male Female

Insurance Information

Insurance Name: _____ BIN Number: _____

Medicare Beneficiaries:

SSN: _____

ID Number: _____ Group Number: _____

☐ I do not have insurance at this time.

I, the undersigned, have read or had explained to me the vaccination information sheet (VIS). I understand the risks and benefits associated with the vaccine(s) and have had my questions answered to my satisfaction. I voluntarily request that the vaccine be given to me or for the aforementioned person for whom I am authorized to make this request. By signing this form, I understand that Community Health Alliance will verify insurance coverage by completing an eligibility check and will bill insurance if coverage is found. By signing this form, I am indicating that I understand that I can access a copy of Community Health Alliance's Notice of Privacy Practices related to health information by visiting https://www.chanevada.org/patients/privacy-policy.

☐ I authorize the vaccine(s) to be administered by a trained student pharmacist.

Signature: _____ Date: _____

Print name of parent, guardian or caregiver: _____

Vaccine Screening Questionnaire			
	Yes	**No**	**Unknown**
Please check if any of the following apply to you: □ 65 years of age or older □ Cystic Fibrosis □ Cerebrovascular Disease □ Diabetes (Type 1 or Type 2) □ Cancer □ HIV □ Obesity (BMI > 30) □ Smoking (current or former) □ Chronic Kidney Disease □ Chronic Lung Conditions (asthma, COPD, Pulm HTN, etc.) □ Chronic Liver Disease (cirrhosis, fatty liver, autoimmune hepatitis, etc.) □ Heart Conditions (heart failure, coronary artery disease, etc.) □ Neurologic Conditions (dementia or Parkinson's Disease) □ Solid organ or stem cell transplant □ Use of corticosteroids or immunosuppressive medications □ Other high risk condition: _____	□	□	□
Are you currently sick or do you have a fever? - If yes, please list your symptoms: _____	□	□	□
Have you or anyone in your household been exposed to, diagnosed with, or have been in quarantine for COVID-19 in the past 14 days?	□	□	□
Have you received passive antibody therapy as treatment for COVID-19 in the past 90 days?	□	□	□
Have you ever had a severe allergic reaction (anaphylaxis) to any medications, latex, food, pets or insects that require the use of treatment with epinephrine (EpiPen)? - If yes, please list allergies: _____	□	□	□
Do you have a blood-clotting disorder, a bleeding disorder or are you taking a blood thinner?	□	□	□
Have you ever received the flu vaccine before?	□	□	□
Have you ever had Guillain-Barre Syndrome?	□	□	□
Have you received any vaccines in the past month? – If yes, which ones? _____	□	□	□
In the last year, have you received a blood transfusion or blood products?	□	□	□
In the last year, have you had radiation therapy?	□	□	□
For women: Are you currently pregnant?	□	□	□

Pharmacy Use Only					
Vaccine Name					
Lot					
Expiration					
Dose					
Route (IM/SQ)					
Site (RD, LD, RA, LA)					

Signature of Pharmacist/Provider: _____ Date: _____

□ Entered into WebIZ Funding: □ 317 □ VFC □ Private

Last Updated: Sept 2025