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**
Do any of the following apply to you? Asthma Diabetes Heart Disease Tobacco Smoker Age 65 or older Immunocompromised	□	□	□
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? _____	□	□	□
Do you have any disease that affects the immune system (cancer, HIV, transplant, etc)?	□	□	□
Are you currently receiving Humira Remicade, Enbrel, methotrexate, azathioprine, 6-mercaptopurine, antivirals, steroids, anticancer or radiation therapy?	□	□	□
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					
Manufacturer					
Dose					
Route (IM/SQ)					
Site (RD, LD, RA, LA)					

Signature of Pharmacist/Provider: _____ Date: _____

□ Entered into WebIZ

Funding: □ 317 □ VFC □ Private

Last Updated: June 2024