Immunization Screening and Consent Form

SpartanNash

To be completed by patient or patient's legal guardian if under 18 years:

First Name: _____ Middle Initial: ____ Last:_____ Phone: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip:_____

Date of Birth _____ /_____ /_____ Age: _____ Gender: M / F Food/Drug Allergies: _____

Primary Care Physician: _____ Phone: ( )_____ - _____

Employee ID (For SpartanNash employees):_____

Medicare Part B: Yes ☐ No ☐ If yes, Name as it appears on Card: _____ Medicare #: (_____-____-_____)

For Medicare Part B recipients:
I authorize the Company and Part B Specialists to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf to Part B Specialists as my Medicare Part B provider.

I would like to receive the following vaccine(s): _____

For all vaccines, please answer the following 6 questions:	
1. Are you sick today?	Yes / No
2. Do you have allergies to medications, food, a vaccine component, or latex? (Examples: eggs, neomycin, gentamycin, yeast or thimerosal) If yes, please list_____	Yes / No
3. Have you ever had a serious reaction after receiving a vaccination?	Yes / No
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	Yes / No
5. Have you ever had a seizure disorder, brain disorder, Guillian Barre Syndrome (a condition that causes paralysis) or other nervous system problem?	Yes / No
6. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	Yes / No
For live vaccines, please answer these additional questions:	
7. Do you have cancer, leukemia, AIDS, or any other immune system problem (lupus, rheumatoid arthritis, etc.)?	Yes / No
8. In the past 3 months, have you taken medications that weaken your immune system such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	Yes / No
9. During the past year have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug?	Yes / No
10. Have you received any vaccinations in the past 4 weeks?	Yes / No

PATIENT CONSENT: I understand that the provider of this vaccination is Family Fare LLC or Nash Finch Company and will be referred to as "The Company."

I have read the information sheet about the vaccinations I am receiving today. I certify that I am at least 18 years old or am the legal guardian and hereby give my consent to the staff of the Company to administer the vaccine(s) listed below. I understand that it is not possible to predict all possible side effects or complications associated with vaccines. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors and assignees hereby agree to release, indemnify, and hold harmless the Company its affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccines listed below.

I agree that the Company will notify my physician of vaccines received by entering vaccine information into the state immunization registery or via fax.

I have received the following vaccine information statements and have had a chance to ask questions which were answered to my satisfaction. The information that I provided above is correct and true to the best of my knowledge. I agree to wait in the vaccination area for approximately 15 minutes for observation by the Company's pharmacist.

I understand that the Company can only bill certain insurances and that the Company will provide me with this receipt that can be submitted to my insurance company for possible reimbursement. It is my responsibility to work with my insurance company to resolve any issues with payment.

Patient Signature: _____ **Date:** _____
Person to receive vaccination or person authorized (if physically unable or less than 18 years of age)

Guardian name and phone number, if recipient is a minor:_____

BELOW LINE FOR PHARMACY USE ONLY

Vaccine	Lot# of Vaccine +/- diluent	Exp. Date	Manufacturer	Dosage	Site of Injection	VIS Date
Influenza (IIV)				0.5 mL	IM L/R Deltoid	
High-Dose Influenza (IIV-HD)			Sanofi	0.5 mL	IM L/R Deltoid	
LIVE Influenza (LAIV)			AstraZeneca	0.2 mL	Intranasal	
Pneumococcal (PPSV23)			Merck	0.5 mL	IM L/R Deltoid	
Pneumococcal (PCV13)			Pfizer	0.5 mL	IM L/R Deltoid	
Tdap				0.5 mL	IM L/R Deltoid	
Shingrix			GSK	0.5 mL	IM L/R Deltoid	
Zostavax			Merck	0.65 mL	SQ L/R Arm	
Other – list below						

Pharmacist Immunizer Name (printed): _____ Signature:_____ Title:_____

Administration Date:_____ Location: _____ Intern Name (if applicable): _____

Date faxed to Provider or entered into the state immunization registry: _____