_____ Scanned in QS1 _____ QS1 Immunization Record _____ Faxed Dr/HD

Temp _____°F

Passed COVID Screening _____

Meningococcal Vaccine Consent Form

(MenB)

Must be 10 – 25 years of age (patients 10-12 must have a prescription)
Remain in the pharmacy for 15 minutes after injection

Schwieterman PHARMACIES' VACCINATION PROGRAM
Protecting Your Family's Health

PERSONAL INFORMATION

[PLACE RX LABEL HERE]

PATIENT PHONE:
( ) -

DATE OF BIRTH: / /

AGE:

☐ FEMALE ☐ MALE

COUNTY:

FAMILY DOCTOR:

MEDICARE/COMMERCIAL INSURANCE ID:

SCREENING QUESTIONS

1.	Are you currently sick with a fever?	☐ Yes ☐ No
2.	Do you have a severe (life-threatening) allergy to **latex** (Bexsero ONLY) or any component (or part) of this vaccine, including aluminum hydroxide, sodium chloride, histidine, sucrose, deoxycholate, **kanamycin**, or polysorbate 80?	☐ Yes ☐ No
3.	Have you ever had a severe (life-threatening) allergic reaction to a previous dose of any vaccine?	☐ Yes ☐ No
4.	For women: Are you currently pregnant or breastfeeding?	☐ Yes ☐ No

Please remain in the pharmacy for 15 minutes following the vaccination. If you leave, you are doing so against medical advice.

I certify that I am: (a) the patient and at least 18 years of age or (b) the parent or legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of Schwieterman Pharmacies, to administer the vaccine I have requested above. I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine 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. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees 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 the vaccine listed above. I acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. I acknowledge that, depending upon my state's law, I may prevent the disclosure of my immunization information by the applicable Provider to the State Registry by using the opt-out form. The Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the Provider reporting my immunization information to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information as required or permitted by law. I voluntarily authorize and direct my healthcare provider at Schwieterman Pharmacies to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at Schwieterman Pharmacies, my Primary Care Physician, my insurance and/or state or federal registries, where required, for the purpose of treatment, payment or other healthcare operations. I further agree to be fully financially responsible for any cost 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.

SIGN

SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE THE REQUEST (PARENT OR LEGAL GUARDIAN) **DATE**

----------FOR CLINIC/OFFICE USE ONLY----------

IMMUNIZER:	TITLE:	DATE OF IMMUNIZATION:	VIS DATE: 8/15/2019

VACCINE/MFG/DOSAGE:	LOT #:	EXP DATE:	SITE OF INJECTION:
☐ Bexsero/GSK/0.5ml ☐ Trumenba/Pfizer/0.5ml			☐ LA/IM ☐ RA/IM

INSURANCE:	STORE:
☐ Medicare ☐ Rx Coverage ☐ Major Med ☐ Cash ☐ _____	☐ CL ☐ CW ☐ MIN ☐ NB ☐ SM ☐ WP

DOSE _____ OF 2 or 3

Updated Aug 2020