



VACCINE CONSENT FORM

<input type="checkbox"/> Immunizer Name: _____	(Internal/Off Site Clinic Information)
<input type="checkbox"/> Phone/Fax Date: ____/____/____	
<input type="checkbox"/> Phone/Fax Time: _____ AM/PM	
<input type="checkbox"/> Registry Date: ____/____/____	

First Name:	MI:	Last Name:	Gender Assigned at Birth:	Age:	Weight:
Home Phone: () -	Date of Birth: / /	Race/Ethnicity: <input type="checkbox"/> African American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Alaska Native <input type="checkbox"/> Other: _____ <input type="checkbox"/> Prefer not to answer			
Home Address:		City:	State:	Zip Code:	
Primary Healthcare Provider:		Provider Address:	Provider Phone/Fax: () -		
Are you covered by commercial or federally funded healthcare insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, provide Insurance Carrier/Cardholder ID/Group Number:			If NO, provide Driver's License (preferred) or Social Security Number:		

I WANT TO BE PROTECTED FROM THE FOLLOWING (PLEASE CHECK ALL THAT APPLY): FLU HEPATITIS A HEPATITIS B HPV TDAP
 MEASLES/MUMPS/RUBELLA (MMR)* MENINGITIS PNEUMONIA SHINGLES VARICELLA* COVID-19: PRODUCT _____ OTHER _____

Please answer the following questions so we can assess the safety and the appropriateness of vaccination:		Yes	No
ALL VACCINES	1. Do you have any of the following symptoms today? Fever, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea		
	2. In the past 14 days, have you had a fever or been exposed to or confirmed to have COVID-19, regardless of symptoms?		
	3. Have you had a physical examination by a healthcare provider in the last year?		
	4. Do you have any allergies to medications, foods (e.g. eggs), latex, or a vaccine component (e.g. gelatin, neomycin, polymyxin, yeast, thimerosal, etc.)? If yes, please list what you are allergic to: _____		
	5. Have you ever had a serious reaction after receiving a vaccine? (swelling, trouble breathing, seizure, etc.)		
	6. Have you had the vaccine (s) you are receiving today before?		
	7. Have you experienced seizures, Guillain-Barre Syndrome, or any other neurological disorder?		
	8. Have you received any vaccines in the past 28 days? If yes, please list vaccine and date: _____		
	9. For Women: Are you currently pregnant, breastfeeding, or are you planning to become pregnant in the next month?		
*LIVE VACCINES	10. Do you have cancer, leukemia, lymphoma, HIV/AIDS, organ transplantation, or any other immune system problem?		
	11. In the past 3 months, have you taken medications that weaken your immune system, such as anticancer drugs, high-dose steroids, chemotherapy, injectable therapy for rheumatoid arthritis, Crohn's disease or psoriasis (e.g. Humira, Enbrel) or had radiation treatments? If yes, list medication, dose, and date last taken: _____		
	12. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? If yes, list medication, dose, and date last taken: _____		

I hereby give my consent to the health care provider of Ayman Care., its affiliates and subsidiaries, to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the vaccine(s) being administered and have received, read and/or had explained to me the CDC's Vaccine Information Statement (VIS) on the vaccine(s) I have elected to receive. I have had the opportunity to ask questions that were answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reaction from the vaccine. I understand that the information contained on this form may be shared with the Stated Health Division (SHD) and/or state immunization registries and will remain confidential and will not be released except as permitted or required by law. If eligible, I authorize Ayman Care to submit a claim for reimbursement on my behalf to Medicare or any other contracted third party payor. If the claim is denied, I understand that I will be responsible for payment. I acknowledge that I have received a copy of the Notice of Privacy Practices. **Furthermore, I agree to remain near the vaccination location for approximately 15-20 minutes after administration for observation by the administering Healthcare Provider.**

X _____ Date: _____
 (SIGNATURE OF PATIENT OR LEGAL GUARDIAN, IF PATIENT UNDER AGE 18) (FOR LEGAL GUARDIANS ONLY: PRINT NAME and RELATIONSHIP)

*** FOR INTERNAL USE ONLY *** **REQUIRED:** obtained verbal consent to treat prior to administration If <18, recommend Well-Child Visit

Vaccine Name: _____ Manufacturer: _____ Dose: _____ Series #: _____ of _____ Vaccine Lot #: _____ Vaccine Exp. Date: _____ Diluent Lot #/Exp. Date: _____	Vaccine Name: _____ Manufacturer: _____ Dose: _____ Series #: _____ of _____ Vaccine Lot #: _____ Vaccine Exp. Date: _____ Diluent Lot #/Exp. Date: _____	Vaccine Name: _____ Manufacturer: _____ Dose: _____ Series #: _____ of _____ Vaccine Lot #: _____ Vaccine Exp. Date: _____ Diluent Lot #/Exp. Date: _____
Injection Site: LEFT/RIGHT; ARM/THIGH Route: IM or SubQ VIS or EUA Fact Sheet Given: ____/____/____ Version Date: ____/____/____	Injection Site: LEFT/RIGHT; ARM/THIGH Route: IM or SubQ VIS or EUA Fact Sheet Given: ____/____/____ Version Date: ____/____/____	Injection Site: LEFT/RIGHT; ARM/THIGH Route: IM or SubQ VIS of EUA Fact Sheet Given: ____/____/____ Version Date: ____/____/____
<input type="checkbox"/> REQUIRED: counseled patient to remain near location for 15 to 30 mins Supervising RPh/Lic#: _____ (if required)		
Immunizer: _____ Date Administered: ____/____/____ Time _____ AM/PM		

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