Vaccine Consent and Assessment

Name: ____ **DOB:** ____________________

Vaccine to be given:

- **Boostrix / Tetanus:** *Medicare will not cover at our facility unless due to injury.*
- **Influenza**
- **Pneumovax23**
- **Prevnar 20:** *65 years and older unless ordered by a Physician.*
- **Shingrix:** *50 years and older. Medicare will not cover at our facility.*
- **Covid Vaccine dose _______ (circle one):** MODERNA PFIZER

Please answer the following questions so we can assess the safety and appropriateness of vaccination:	Yes	No
1. Do you have a fever or illness today?		
2. Do you have an allergy to medications, latex, food, or vaccines? **If YES, please list:**		
3. Have you had a serious reaction after receiving a vaccine?		
4. Have you experienced seizures, Guillain-Barre Syndrome, or any other neurological disorder?		
5. Have you received any vaccines in the past 28 days? **If YES, list vaccine and date:**		
6. ***FOR WOMEN***: Are you currently pregnant, breastfeeding or planning to become pregnant in the next month?		

I hereby give my consent to Van Wert Family Physicians to administer the vaccine I requested. I understand the risks and benefits associated with the vaccine being administered and have received, read and/or had explained to me the CDC's vaccine information statement (VIS) on the treatment, there is no guarantee that I will not experience an adverse reaction from the vaccine. I fully release and hold harmless Van Wert Family Physicians, its physicians, and employees from any and all liabilities or claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) I receive. I understand that the information contained on this form may be shared with the stated Health Division 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 VWFP to submit a claim for reimbursement to Medicare, Commercial Insurance or any other contracted third party payer. If the claim is denied, I understand that I will be responsible for payment.

X ____ **Date:** ________________________

(Signature of patient or legal guardian, if patient under 18)

____________________ Office Use Only ____________________

Vaccine Name: _________________	**Vaccine Name:** _________________	**Vaccine Name:** _________________
Lot # _________ Exp. Date _______	Lot # _________ Exp. Date _______	Lot # _________ Exp. Date _______
Injenction Site _________________	Injenction Site _________________	Injenction Site _________________
VIS given: YES or NO	VIS given: YES or NO	VIS given: YES or NO
Nurse Sig: ____________________	Nurse Sig: ____________________	Nurse Sig: ____________________
Provider Sig: ___________________	Provider Sig: ___________________	Provider Sig: ___________________