Vaccine Intake Consent Form

GATEWAY MEDICAL PHARMACY
1125 NE 99TH AVE, PORTLAND, OR 97220 (503) 254-7383

Last Name **First Name** **Date of Birth** / / **Sex Assigned At Birth** M / F

Address **Phone Number**

Race (circle response): American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, Black or African-American, White, Unknown, Other _____

Ethnicity (circle response): Hispanic or Latino, Non-Hispanic, Unknown

I would like the following vaccines (circle response): COVID-19, Flu, TDAP, Shingles, Pneumonia, Other: _____

	YES	NO	I DON'T KNOW
1. Have you been diagnosed with, experienced symptoms of, or had close contact with anyone who has tested positive for COVID-19 in the last 14 days?	☐	☐	☐
2. Are you feeling sick today?	☐	☐	☐
3. Have you ever received any other vaccinations or skin tests in the past 8 weeks?	☐	☐	☐
4. Have you ever had a reaction to any vaccine or an injectable medication, including fainting or dizziness?	☐	☐	☐
5. Have you ever had an allergic reaction to latex, medications, food or vaccines? *Examples (not all inclusive): Polyethylene glycol (PEG), polysorbate, eggs, gelatin, bovine protien, gentamicin, polymixyn, neomycin, phenol yeast or thimerosal* *If yes, please list below:* _____	☐	☐	☐
6. Have you ever had a seizure disorder, a brain disorder, history of Guillian-Barre syndrome or any other nervous system problem?	☐	☐	☐
7. Do you have any chronic health conditions? If yes please list below: _____	☐	☐	☐
8. Do you have a condition that may weaken your immune system? *Examples: Cancer, leukemia, lymphoma, HIV/AIDS, transplant*	☐	☐	☐
9. Do you currently take any medications that may weaken your immune system?	☐	☐	☐
10. Are you currently taking any medication to thin the blood?	☐	☐	☐
11. For women: Are you pregnant or may become pregnant in the next month?	☐	☐	☐

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet(s) corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize Gateway Medical Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid 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.

ACCEPTANCE OF FINANCIAL RESPONSIBILITY: Notwithstanding anything set forth above, I agree that I am responsible for and will promptly pay on demand any and all obligations to Gateway Medical Pharmacy including all self-pay balances as well as those charges for services not covered or disallowed by my insurance carrier.

DISCLOSURE OF RECORDS: I understand that Gateway Medical Pharmacy may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at Gateway Medical Pharmacy (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that Gateway Medical Pharmacy will use and disclose my health information as set forth in the Gateway Medical Pharmacy Notice of Privacy Practices (copy is available in-store, online or by requesting a paper copy from the pharmacy). Vaccine Clinics: If I am receiving a vaccine through a vaccine clinic, I understand that my name, vaccine appointment date and time will be provided to the clinic coordinator.

X

Signature of patient to receive vaccine or person authorized to make the request (parent/guardian) **Date**

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Last Name	First Name	Date of Birth

Vaccine Administration Information for Immunizer/Pharmacist use only

Vaccine #1

Administration Date	Vaccine		VIS Date	Manufacturer
				○ L ○ R
Lot #	**Exp. Date**	**Route**		**Site** / **Volume (mL)**

Vaccine #2

Administration Date	Vaccine		VIS Date	Manufacturer
				○ L ○ R
Lot #	**Exp. Date**	**Route**		**Site** / **Volume (mL)**

Vaccine #3

Administration Date	Vaccine		VIS Date	Manufacturer
				○ L ○ R
Lot #	**Exp. Date**	**Route**		**Site** / **Volume (mL)**

Vaccine #4

Administration Date	Vaccine		VIS Date	Manufacturer
				○ L ○ R
Lot #	**Exp. Date**	**Route**		**Site** / **Volume (mL)**

Immunizer/Pharmacist: Prior to administration a pharmacist has reviewed ALERTIIS, and other relevant resources and has deemed immunization appropriate.

Administering Immunizer Name & Title	Administering Immunizer Signature

Place RX Back Tags Below: