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Patient Walk In Consent Form

Clinic Site Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name & First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 of Social: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Fever or feeling ill today? |  No  |  Yes – Defer until feeling better |
| History of severe allergic reaction, including anaphylaxis to any component of this vaccine? | No  |  Yes – STOP do not vaccinate |
| History of severe allergic reaction, including anaphylaxis to any vaccine, other than this vaccine? | No  |  Yes – Defer; consult with PCP |
| History of severe allergic reaction, including anaphylaxis to an injectable therapy? | No  |  Yes – Defer; consult with PCP |
| History of severe allergic reaction due to any cause? | No  |  Yes – Require 30 min observation |
| Do you have a weakened immune system, caused by something like HIV infection or cancer or do you take immunosuppressant drugs or therapies?  | No  |  Yes – Defer; consult with PCP |
| Are you pregnant or breastfeeding? | No  |  Yes – Defer; consult with PCP |
| Have you ever had Guillain-Barѓe syndrome?  | No  |  Yes – Defer; consult with PCP |
| For COVID-19 Immunization |  |  |
| Have you ever received a dose of COVID-19 Vaccine? DATE:  | No  |  Yes – ensure vaccine type & appropriate interval |
| Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?  | No  |  Yes – STOP do not vaccinate for 90 days since last treatment date |

CONSENT

 I consent to the above vaccine(s) to be administered. I have been given the Vaccine Information Statements from the Centers for Disease Control, and understand the possible side effects that should be taken into consideration prior to administration of the vaccine. I give permission to Pathways Wellness Program and staff to vaccinate and to report any data collected on this form to the required state and/or federal agencies as required. Privacy Practices: I acknowledge that Notice of Privacy Practices were made available to me.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Screening questions reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Print signature by Immunization Clinician)

**Billing Form: to be completed by the Immunization Clinician**

**Vaccines Administered**

|  |  |  |  |
| --- | --- | --- | --- |
| **Flulaval** (90686)  | \_\_\_\_\_\_\_  | **Bexsero-** (90620)  | \_\_\_\_\_\_\_  |
| **Fluad** - HD Flu (90694) | \_\_\_\_\_\_\_  | **Menveo -** Meningitis ACWY (90734) | \_\_\_\_\_\_\_ |
| **Shingrix**- Shingles (90750)  | \_\_\_\_\_\_\_ | **Moderna –** Covid 19 | \_\_\_\_\_\_\_ |
| **Prevnar 20**- PCV20 (90677)  | \_\_\_\_\_\_\_  | **Pfizer –** Covid 19-12yrs+ (91320) | \_\_\_\_\_\_\_  |
| **Pneumovax 23** (90732) | \_\_\_\_\_\_\_  | **Arevxy-**RSV (90679) | \_\_\_\_\_\_\_ |
| **Boostrix**- TDAP/Tetanus Diphtheria Pertussis (90715) | \_\_\_\_\_\_\_  | **Abrysvo-**RSV(90678) | \_\_\_\_\_\_\_ |
|  |  | **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | \_\_\_\_\_\_\_ |

**Vaccine Administration Record**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Vaccine** | **Dose Number** | **Date Administered** | **Site and Route** | **Manufacturer / Lot No.** | **VIS Date** | **Date VIS given to patient** |
| **INFLUENZA** |  |  | RD LDIM SC |  | 08/06/2021 |  |
| **FLUAD HD** |  |  | RD LDIM SC |  | 08/06/2021 |  |
| **Shingrix** -Shingles | Dose 1Dose 2 |  | RD LDIM SC |  | 02/04/2022 |  |
| **Prevnar 20** Pneumonia conjugate PCV20 |  |  | RD LDIM SC |  | 05/12/2023 |  |
| **Pneumovax 23** Pneumonia polysaccharide PPSV23 |  |  | RD LDIM SC |  | 10/30/2019 |  |
| **Boostrix**Tdap |  |  | RD LDIM SC |  | 08/06/2021 |  |
| **Menveo**Meningitis ACWY |  |  | RD LDIM SC |  | 08/06/2021 |  |
| **Pfizer**Covid 19 | Booster |  | RD LDIM SC |  | 10/19/2023 |  |
| **Moderna**Covid 19 | Booster |  | RD LDIM SC |  | 10/19/2023 |  |
| **Arexvy/Abrysvo**RSV |  |  | RD LDIM SC |  | 10/19/2023 |  |
| **Other** |  |  | RD LDIM SC |  |  |  |

Vaccine(s) administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Immunization Clinician Signature)