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Patient Walk In Consent Form

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

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

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

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

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

Insurance ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicare ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| 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 |
| Have you had any LIVE vaccines in the past 30 days? | No | Y- Yes- it is recommended to space live vaccines by > or = 4 weeks for full efficacy |

**CONSENT**: I consent to the above vaccine(s) to be given to my student. I have been given the [Vaccine Information Statements](https://www.cdc.gov/vaccines/hcp/current-vis/?CDC_AAref_Val=https://www.cdc.gov/vaccines/hcp/vis/current-vis.html) 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 my student 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 name by Immunization Clinician)

**Billing & Vaccine Administration Record: to be completed by the Immunization Clinician**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Vaccine** | **Date Administered** | **Dose #** | **Site and Route** | **Manufacturer / Lot No.** | **VIS Date** | **Date VIS given to patient** |
| **INFLUENZA**  (90656) |  |  | RD LD  IM SC |  | 01/31/2025 |  |
| **FLUAD HD (65 yrs+)**  (90653) |  |  | RD LD  IM SC |  | 01/31/2025 |  |
| **COVID (12yrs+)** (91320) |  |  | RD LD  IM SC |  | 01/31/2025 |  |
| **Shingrix** -**Shingles (50 yrs+)**  (90750) |  | Dose 1  Dose 2 | RD LD  IM SC |  | 02/04/2022 |  |
| **Arexvy/Abrysvo – RSV (60 yrs+)**  (90679)/(90678) |  |  | RD LD  IM SC |  | 01/31/2025 |  |
| **Prevnar 20** - **PCV20 (50 yrs+)** Pneumonia conjugate  (90677) |  |  | RD LD  IM SC |  | 05/12/2023 |  |
| **Pneumovax 23 - PPSV23**  Pneumonia  (90732) |  |  | RD LD  IM SC |  | 10/30/2019 |  |
| **Boostrix -Tdap**  (90715) |  |  | RD LD  IM SC |  | 01/31/2025 |  |
| **Menveo - Meningitis ACWY**  (90734) |  |  | RD LD  IM SC |  | 01/31/2025 |  |
| **Bexsero - Meningitis B**  (90620) |  |  | RD LD  IM SC |  | 01/31/2025 |  |
| **Rabavert – Rabies**  (90675) |  | Dose 1  Dose 2 | RD LD  IM SC |  | 06/02/2022 |  |
| **Other** |  |  | RD LD  IM SC |  |  |  |
| **Other** |  |  | RD LD  IM SC |  |  |  |

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

(Immunization Clinician Signature)