VACCINE CONSENT FORM

NAME (PLEASE PRINT): ____

DOB: ______________________ PHONE: ______________________________

ADDRESS: ____

CITY: __________________________ STATE: __________ ZIP: _______________

I WANT TO BE PROTECTED FROM THE FOLLOWING (CHECK ALL THAT APPLY):

☐ HEPATITIS A ☐ HEPATITIS B ☐ TDAP ☐ SHINGLES ☐ MMR* ☐ FLU

☐ MENINGITIS ☐ PNEUMONIA ☐ COVID-19 ☐ VARICELLA* ☐ RSV ☐ HPV

	Please answer the following questions so we can assess the safety and appropriateness of your 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 diagnosed with COVID-19, regardless of symptoms?		
	3. Do you have any allergies to medications, foods (e.g. eggs), latex, or a vaccine component (e.g. gelatin, neomycin, polymyxin, yeast, thimerosal, polyethylene glycol, etc.)? If yes, please list: ______________		
	4. Have you ever had a serious reaction after receiving a vaccine (swelling, trouble breathing, seizure, etc.)?		
	5. Have you ever experienced seizures, Guillain-Barre Syndrome, or any other neurological disorder?		
	6. Have you received any other vaccines or skin tests in the past 4 weeks? If yes, please list: ______________		
	7. **For women:** Are you currently pregnant, breastfeeding, or are you planning to become pregnant in the next month?		
***LIVE ONLY**	8. During the past year, have you received a transfusion of blood or blood products, been given immune (gamma) globulin or an antiviral drug, or received COVID-19 antibody treatment? If yes, list medication, dose, and date last taken: ______________		
	9. Do you have cancer, leukemia, lymphoma, HIV/AIDS, organ transplantation, or any other immune system problem?		
	10. 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: ______________		

I have received and read the informed consent for the vaccine(s) requested above. I have had the opportunity to ask questions. I accept that services might be rendered in a non-private setting. I hereby consent to the administration of the above requested vaccine(s). Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators and assignees, Mackey Family Practice and their employees, owners and representatives, as well as the company sponsoring this event and their agents, representatives, employees, successors, assignees, governing bodies, and advisory committees from any and all claims, demands, actions and causes of action, which may result from participation in the program. I will communicate the information provided to me today about my vaccination to my primary care provider if I have one.

Signature: ________________________________ Date: ____________

FOR INTERNAL USE ONLY

Vaccine Name: ______________________	Vaccine Name: ______________________
Manufacturer: ______________________	Manufacturer: ______________________
Dose: ______mL Lot #: _________ Exp Date: __________	Dose: ______mL Lot #: _________ Exp Date: __________
Injection Site: L R ________________	Injection Site: L R ________________
Route: IM SQ	Route: IM SQ
VIS Given: ___/___/___ Version Date: ___/___/___	VIS Given: ___/___/___ Version Date: ___/___/___

Immunizer Signature : ____________________________ Date : ____________

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Below is a list of the insurance plans that Mackey Family Practice will file for the 2024–2025 flu shot.

Please only complete the insurance portion that applies to your plan.

The insurance we file must be your **PRIMARY** insurance. Please include the insurance claims address below!!

If you do not have one of these insurance plans, the cost of the flu shot is $45.

Name: ___________________________________ Date of Birth: ___________________

SC State BCBS ID#: ______________________________________

If you are a Spouse/Dependent, please list the card holder's name and DOB.

Name: __________________________ Date of Birth: ___________________________

Medicare (If you do not have Medicare Advantage Plan) ID: _______________________________

United Healthcare ID#: ____

Cigna Healthspring ID#: ____

BCBS Medicare Advantage ID#: ____

Aetna Medicare Advantage ID#: ____

Wellcare Dual Medicare Advantage ID#: ____

***Insurance Claims Address for Billing**:

City: _________________ State: __________________ Zip Code: ____________________________

Phone Number: ___________________________

*****Failure to include the claims address may result in a denial of coverage for the flu shot. *****

****PLEASE NOTE: WE DO NOT ACCEPT MEDICAID! ****