VACCINE ADMINISTRATION CONSENT FORM
BROOKSHIRE GROCERY COMPANY; ENGLISH VERSION (rev 4/17/2024)

Patient Name:	**Date of Birth: - -**	**Phone:**
Address:	**City:**	**State: Zip:**
Primary Doctor: **Fax #:**	**Vaccine(s) to Receive:**	

PLEASE ANSWER THE FOLLOWING QUESTIONS: **Arm: __Left __Right**

__Yes __No Are you sick today?
__Yes __No Do you have allergies to eggs, gelatin, food, neomycin, **latex**, other medications, or vaccines? **Please list: _____**
__Yes __No Have you ever had a serious reaction after receiving a vaccination? (e.g. hives, trouble breathing, or swelling of the face)
__Yes __No Do you have any or multiple of the following chronic medical conditions: chronic heart, lung, or liver disease, diabetes, alcoholism, or use tobacco products?
__Yes __No Do you have cancer, leukemia, HIV/AIDS, bone marrow disease or any other immune system problems?
__Yes __No In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation therapy?
__Yes __No Have you had a seizure, coma, brain, or other nervous system problem after a vaccine such as Guillian-Barre syndrome (an illness with sudden muscle weakness and some loss of senses in the fingers and toes)?
__Yes __No During the past year, have you received a transfusion of blood/blood products, been given immune (gamma) globulin or an antiviral drug?
__Yes __No Have you had any vaccinations in the past 4 weeks? **Please list: _____**
__Yes __No **For women:** Are you pregnant or is there a chance you could become pregnant during the next month?
__Yes __No Are you 65 years old or older? **Age: _____**

INFORMATION FOR THE PERSON TO RECEIVE THE VACCINE:

I agree that the person named above will receive the vaccine indicated and that this person will have a vaccine administered by injection to prevent infectious disease. I acknowledge that I received a current copy of the Vaccine Information Statement for this vaccine and have had the opportunity to ask questions concerning the benefits and risks of the vaccine and the diseases it prevents. ***I understand that I may be asked to stay near the pharmacy at least 15 minutes after the vaccine has been administered to ensure that no adverse reactions will occur.*** I freely and voluntarily authorize the administration of these vaccines to me or the person named above for whom I am authorized to make this decision.

By signing this form, I authorize the release of any medical or other information necessary to process this claim. I also request and authorize the payment of government benefits to the party who accepts assignment. My signature will also confirm my acknowledgement of receiving a copy of the Brookshire Grocery Company (BGC) Notice of Privacy Practices. If I decide to leave less than 15 minutes after the vaccine has been administered, my signature indicates that I will not hold any BGC employee liable for any adverse reaction that may occur outside of their supervision.

Signature of Patient or Parent/Legal Guardian (if under 18) X: _____

For Pharmacy Use Only

Has Patient's Primary Doctor Been Notified? (circle one): YES NO **Protocol Doctor:** *Dr. Ryan Hendren*

Date: **Time:** **AM/PM** **Partner Initials:** **COVID Questionnaire Reviewed RPh Initials:**

Vaccine Type/Trade Name(s)	Dose	Manufacturer	Route	Lot #	Exp Date	Admin Site	VIS	Dose # (Circle)
Influenza/ *Flulaval, Fluzone, Flucelvax, Afluria, Fluarix, Fluzone HD, Flublok, Fluad*	0.25 mL/ 0.5 mL/0.7 mL	Sanofi/GSK/ Sequiris	IM			RD LD	8/6/2021	N/A
Spikevax 2023-24 Formula (Green or Blue label)	0.25/0.5 mL	Moderna	IM			RD LD	10/19/2023	N/A
Comirnaty 2023-24 Formula (Blue or Gray cap)	0.3 mL	Pfizer	IM			RD LD	10/19/2023	N/A
Novavax Covid-19 2023-24 Formula	0.5 mL	Novavax	IM			RD LD	10/19/2023	1 2
Pneumococcal (PPSV23)/ *Pneumovax23*	0.5 mL	Merck	IM/SQ			RD LD	10/30/2019	N/A
Pneumococcal (PCV20/15)/ *Prevnar20/Vaxneuvance*	0.5mL	Pfizer/Merck	IM			RD LD	5/12/2023	N/A
Td/ *Tenivac*	0.5 mL	Sanofi Pasteur	IM			RD LD	8/6/2021	N/A
Tdap/ *Boostrix, Adacel*	0.5 mL	GSK/Sanofi	IM			RD LD	8/6/2021	N/A
Hepatitis A/ *Havrix, Vaqta*	0.5mL/1 mL	GSK/Merck	IM			RD LD	10/15/2021*	1 2 3
Hepatitis B/ *Recombivax, Engerix, Heplisav-B*	0.5mL/1 mL	Merck/GSK	IM			RD LD	5/12/2023*	1 2 3 *(4)*
Hep A & Hep B/ *Twinrix*	1 mL	GlaxoSmithKline	IM			RD LD	*Included	1 2 3 *(4)*
HPV/ *Gardasil 9*	0.5 mL	Merck	IM			RD LD	8/6/2021	1 2 3
Meningococcal ACWY/ *Menquadfi, Menveo*	0.5 mL	Sanofi/Novartis	IM			RD LD	8/6/2021	1 2
Serogroup B Men/ *Trumenba, Bexsero*	0.5 mL	Pfizer/GSK	IM			RD LD	8/6/2021	1 2 3
RSV/ Abrysvo	0.5mL	Pfizer	IM			RD LD	8/6/2021	N/A
RSV/ Arexvy	0.5 mL	GSK	IM			RA LA	08/6/2021	N/A
Zoster/ *Shingrix*	0.5 mL	GSK	IM			RD LD	2/4/2022	1 2
Other								

BILLING INFORMATION (circle one)

TP (See Below)	Cash	Medicare B

BIN: PCN: GRP #: ID #: PC:

(Pharmacy Stamp Here)

Immunizer Signature:
☐ Pharmacist ☐ Intern ☐ Technician

Pharmacist Signature:
(If supervising)

Printed Name of Immunizer:

Date of Vaccine/VIS Given:

Reasor's

Patient Name: _____

DOB: _____

Medicare #: _____

Assignment of Benefits
Specifically for Immunization billing to Medicare Part B

I authorize payment of MEDICARE benefits be made to Brookshire Pharmacy, Super 1 Pharmacy, or Fresh Pharmacy #_____ for any services furnished to me on assignment by the pharmacy. I authorize realease of my personal/medical information to Brookshire Pharmacy, Super 1 Pharmacy, or Fresh Pharmacy #_____, my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine the benefits or the benefits payable for related services.

I agree to pay all amounts that are not covered by Medicare Part B including applicable co-payments and/or deductibles for which I am responsible.

I understand that if Medicare does not pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the Medicare Summary Notice that is sent to me from Medicare

_____ _____

Beneficiary Signature Date