

CLINIC										
ADMIN USE ONLY										
	BILLED		CASH		GRITS					

IMMUNIZATION CONSENT FORM

All sections must be filled completely

PATIENT INFORMATION														
LAST NAME						FIRST NAME					M.I			
DATE OF BIRTH						GENDER M			MALE		FEMALE			
ADDRESS											APT#			
CITY								STAT	ΓE		ZIP			
HOME PHONE								CELL PH	IONE					
					IN	NSURANCE	INFO	RMATIO	N					
DO YOU HAVE	ANY PR	RESCRIPT	ΓΙΟΝ Ι	INSURAN	CE?		□ MEDI	CARE	□ PR	RIVATE	☐ MEDICA	AID.	□NO	
INSURANCE BI	N #							PC	N #					
GROUP#					MEDIC	CARE / PRI	VATE IN	ISURANC	E ID#					
,	*OPTIO	NAL*		PR:	IMARY	CARE PHY	YSICIA	N INFO	RMATI	ON	*OPT	IONAL	*	
NAME														
ADDRESS														
CITY								STAT	ΓE		ZIP			
PHONE								FAX	(
	_					VACC	CINATI	ON	•					
VACCINE REQUESTED														
CASE HISTORY AND LISTED CONTRAINDICATIONS														
PLEASE ANSWER THE FOLLOWING QUESTIONS														
ALL VACCINES										NS				
				PLE	ASE AN				JESTIC	ONS				
					UESTI	ALL V			JESTIC	ONS	YES	NO	DON'T KNO	ow
1. Have you ha	ad a phy	rsical exa	amina	QI	UESTI	ALL V			JESTIC	ONS	YES	NO O	DON'T KNO	ow
1. Have you ha			amina	QI	UESTI	ALL V			UESTIC	DNS				ow
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2. Are you sick	today? allergion, thime	es to me crosal, or	dicat r neoi	QI ation with ions, egg: mycin? If	UESTI nin the p s or oth Yes, list	ALL V ON past year? per food, a stallergies I	VACCIN Vaccine below	compon		ONS	0	0	0	ow
2. Are you sick 3. Do you have latex or gelatin 4. Have you ex 5. Do you have	today? allergion, thime ver had a	es to me rosal, or a serious g-term l	edicat r neoi s reac healtl	Quation with tions, egg: mycin? If tion after h probler	uESTI nin the p s or oth Yes, list r receiv m with	ALL V ON past year? per food, a v t allergies being a vaccion	vaccine below nation?	componing diseas	ent,		0 0 0	0	0 0	OW
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I certify that I am: (a) the patient and at least 18 years of age; or (b) the parent or legal guardian of the patient ('Ward'). I have received a copy of the applicable Vaccine Information Statement(s) and I have read the adverse reactions associated with the administration of vaccine(s). Furthermore, I consent to the administration of the vaccine(s) requested above to me or my Ward and acknowledge that, as a condition to administration of the vaccine(s), myself or my Ward must remain under observation of the administering pharmacist for a period of not less than 15 minutes. I understand that a copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about the immunization(s). I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization(s) or the receipt of the immunization(s) by the person named above for whom I am the Ward. My medical record may be shared with my primary care provider or other healthcare provider and the medical record of my Ward may be shared with his/her primary care provider or other healthcare provider. I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives, and assigns, hereby release Managed Health Solutions, LLC, and its affiliates, subsidiaries, divisions, directors, contractors, agents, and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt by my Ward of this or these immunization(s). Neither Managed Health Solutions, LLC, nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or in any way accountable for any loss, injury, death, or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccine(s) described above. I authorize Managed Health Solutions, LLC to (a) notify me or my Ward's primary care provider of the vaccine administered and to provide same with copies of all vaccination records; (b) to enter my or my Ward's vaccine information on the Georgia Registry of Immunization Transactions; and (c) make any other disclosures required by law: and (d) to bill me for any payments, copayments, deductibles, or administration charges that are due that are not covered by my health insurance or Medicare/Medicaid. Managed Health Solutions, LLC will use and disclose my personal and health information or the personal and health information of my Ward, to receive payment of the care provided, and for other health care operations. Healthcare operations include those activities performed to improve the quality of care. I acknowledge that I have received a copy of the Notice of Privacy Practices.

For Patients receiving Live Vaccines only: I further certify that I have read the list of contraindications to the vaccine(s) set forth above and neither me or my Ward have a contraindication to the vaccine[s] to be administered.

PATIENT / LEGAL GUARDIAN SIGNATUREDATEDATE										
			!!! PHA	RMACY U	SE ONL	Y !!!				
			ADMI	NISTRATIV	E RECO	RD				
	VACCINE				EXP DATE			VIS VERSION/DATE		
1	DATE ADMIN	ISTERED		MANUFACTURER			LOT#			
	DOSAGE	ROUTE OF ADMIN		ı		DATE M.D NOTIFIED				
								_		

VACCINE EXP DATE VIS VERSION/DATE 2 **DATE ADMINISTERED MANUFACTURER** LOT# DOSAGE **ROUTE OF ADMIN DATE M.D NOTIFIED** VACCINE **EXP DATE** VIS VERSION/DATE 3 **DATE ADMINISTERED MANUFACTURER** LOT# **DATE M.D NOTIFIED DOSAGE ROUTE OF ADMIN** ADMINISTERING PHARMACIST INFORMATION NAME & TITLE LICENSE # **Managed Health Solutions, LLC** 3070 A Business Park Drive PHARMACY INFORMATION Norcross, GA 30070 770-496-5314 Fax: 770 496-7445 **ADVERSE EVENTS/ COMPLICATIONS & NOTES**

REPORT ALL ADVERSE REACTIONS TO THE FEDERAL VACCINE ADVERSE EVENT REPORTING SYSTEM