Bee Well PHARMACY

VACCINE CONSENT FORM

First Name:	MI:	Last Name:			
Home Phone number:	Date of Birth:	Age:	Weight:	Gender:	Ethnicity:
Home Address:		City:		State:	Zip code:
Insurance Carrier:	Cardholder ID:			Group number:	
Doctor/Primary Healthcare Provider:	Provider phone number:		Medicare Part B number (if applicable):		

Requested Vaccine (please check all that apply): ☐ FLU ☐ PNEUMONIA ☐ SHINGLES ☐ TDAP
☐ OTHER (PLEASE SPECIFY): _____

Please answer the following questions so we can assess the safety and the appropriateness of vaccination

- Have you had a physical examination by a healthcare provider in the last year? ☐ Yes ☐ No
- Do you feel sick today? ☐ Yes ☐ No
- Do you have any allergies to latex, medications, food (e.g. eggs) or vaccine component (e.g. gelatin, neomycin, polymycin, yeast, thimerosal, etc.)? If yes please list: _____ ☐ Yes ☐ No
- Have you ever fainted or felt dizzy when receiving a vaccine? ☐ Yes ☐ No
- Have you ever had a serious reaction to a vaccine? (Swelling, trouble breathing, seizures) ☐ Yes ☐ No
- Have you ever experienced seizures, Guillain-Barre Syndrome, or any other neurological disorder? ☐ Yes ☐ No
- Have you received any vaccines in the past 28 days? ☐ Yes ☐ No

If yes, please list vaccine and date: _____

- **For Women:** Are you currently pregnant, breastfeeding, or are you planning to become pregnant in the next month?
  ☐ Yes ☐ No

I certify that I am: (1) the Patient and at least 18 years of age; (2) the parent or legal guardian of the minor Patient; or (3) the legal guardian of the Patient, I hereby give my consent to the healthcare provider at BeeWell Pharmacy to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received read/had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering health provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless BeeWell Pharmacy, as applicable, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that (a) I understand the purpose/benefits of my state's immunization registry ("Registry"); (b) I may, if my state permits, object to BeeWell Pharmacy disclosing my immunization information to the immunization Registry by providing BeeWell Pharmacy with a state approved Registry disclosure opt out form; and (c) Unless I authorize BeeWell Pharmacy, as applicable, to (i) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information to my healthcare professionals, Medicare, Medicaid, or other third party payer as necessary to effectuate care or payment, (ii) submit a claim to my insurer for the above requested items and services, and (iii) request payment of authorized benefits be made on my behalf to EJBRX LLC DBA BeeWell Pharmacy, as applicable, with respect to the above requested items and services. I further agree to be fully financially responsible for any co-sharing amounts, including co-pays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payments for which I am financially responsible is due at the time of service or, Bee Well Pharmacy, invoices me after the time of service, upon receipt of such invoice.

_____

Patients Signature Date

_____

Patient name/Relationship (if minor)