

Costco Pharmacy Immunization Consent Form



PATIENT INFORMATION

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|--|---|--------------------|-------------------------------|-------------------------|
| PATIENT'S LAST NAME | PATIENT'S FIRST NAME | MI | GENDER (M/F) | BIRTH DATE (MM/DD/YYYY) |
| ADDRESS | | CITY | STATE | ZIP |
| 10-DIGIT MOBILE PHONE NUMBER | COUNTY (WHERE PATIENT LIVES) | | PATIENT'S EMAIL | |
| PRIMARY CARE PROVIDER (MD, DO, NP, PA) | | PROVIDER PHONE/FAX | PRIMARY CARE PROVIDER ADDRESS | |
| RACE – Check all that apply | American Indian or Alaska Native | Asian | Black or African American | Caucasian |
| | Native Hawaiian or Other Pacific Islander | Other _____ | ETHNICITY – Check one | |
| | | | Hispanic or Latino | |
| | | | Not Hispanic or Latino | |

INSURANCE INFORMATION

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|-----------|------|------------|------------------------------|---------|----------|------|
| UNINSURED | CASH | MEDICARE # | OTHER INSURANCE CARRIER NAME | GROUP # | BIN/PCN: | ID # |
|-----------|------|------------|------------------------------|---------|----------|------|

VACCINE(S) REQUESTED

| | | | | | |
|----------------------|---------------|-----------------|------------------------|-------------------------------|-------------|
| Influenza injectable | Meningococcal | Hepatitis A & B | Varicella (Chickenpox) | Whooping Cough (Tdap, DTaP) | Other _____ |
| Influenza nasal | Hepatitis A | HPV | Zoster (Shingles) | Measles Mumps & Rubella (MMR) | Other _____ |
| Pneumococcal | Hepatitis B | Polio | Tetanus (Td) | COVID (indicate Brand) _____ | |

PRECAUTIONS AND CONTRAINDICATIONS (Please check yes or no for each question.)

| | | | | | |
|---|-----|----|---|-----|----|
| 1. Are you sick today?..... | Yes | No | 8. Do you have a history of Guillain-Barre Syndrome?..... | Yes | No |
| 2. Do you have allergies to medications, food or vaccines?..... | Yes | No | 9. Have you had a seizure, brain or nerve problem?..... | Yes | No |
| Allergies _____ | | | 10. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?..... | Yes | No |
| 3. Have you ever had a serious reaction after receiving an immunization?.... | Yes | No | 11. For women: Are you pregnant or is there a chance you could become pregnant during the next month?..... | Yes | No |
| 4. Have you ever fainted or felt dizzy after receiving an immunization?..... | Yes | No | 12. Have you received any vaccinations in the past 4 weeks?..... | Yes | No |
| 5. Are you currently being treated for a long-term health problem such as heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder?..... | Yes | No | If yes, what vaccines? _____ | | |
| 6. Are you currently being treated for cancer, leukemia, AIDS or any other immune system problem?..... | Yes | No | 13. Are you allergic to eggs?..... | Yes | No |
| 7. Are you currently taking cortisone, prednisone, other steroids or anti-cancer drugs, or have you had X-ray treatments?..... | Yes | No | 14. Are you allergic to latex?..... | Yes | No |
| | | | 15. For tetanus: do you have a cut, injury, puncture or open wound?..... | Yes | No |

ADVERSE REACTIONS

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of any vaccine causing serious harm, or death, is extremely small. Local symptoms may include: slight tenderness, redness, itching or swelling at the site of injection.

Systemic symptoms may include: fever, malaise and muscle pain. Other systemic symptoms may occur infrequently. These reactions usually begin 6 to 12 hours after immunization and can persist for a few days. Immediate presumable allergic reactions such as hives, angioedema, allergic asthma or systemic anaphylaxis occur rarely after immunization. These reactions may result from hypersensitive reactions in people with severe egg allergy, and such people should not be given certain vaccines that contain eggs. People with documented immunoglobulin E (IgE)-mediated hypersensitivities to eggs or any other vaccine components, including thimerosal, may also be at increased risk of reactions from immunizations.

In the case of a severe reaction such as a high fever, behavior changes or flu-like symptoms that occur after vaccination, see a doctor right away. Signs of an allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, or dizziness within a few minutes to a few hours after the shot.

I have read the adverse reactions associated with the administration of vaccines. The vaccine you are receiving may have been authorized by the FDA under Emergency Use Authorization (EUA). Vaccines authorized under EUA have been rigorously assessed for efficacy and safety. 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 these immunizations. 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 below for whom I am the legal guardian ("Ward"). My medical record may be shared with my physician or other healthcare provider and the medical record of my Ward may be shared with his/her physician or other healthcare provider. I am requesting that the immunization(s) be given to me or my Ward. I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives and assigns, hereby release Costco, 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 Costco 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 vaccines described above. Costco will use and disclose your personal and health information or the personal and health information of your Ward, to treat you or your Ward, to receive payment of the care we provide, and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to you and your Ward's personal health information. I acknowledge that I have received a copy of the Notice of Privacy Practices.

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|--------------------------|------------|
| SIGNATURE/LEGAL GUARDIAN | PRINT NAME |
|--------------------------|------------|

ADMINISTRATIVE RECORD For pharmacy use only

| | | |
|--|---|------------------|
| DATE OF VACCINATION/DATE VIS GIVEN | PHARMACY NAME | PHARMACY ADDRESS |
| PHARMACIST/PREScriBER SIGNATURE - SUBSTITUTION PERMITTED | PHARMACIST/PREScriBER SIGNATURE - DISPENSE AS WRITTEN | |
| VACCINE: _____ SITE OF INJ.: _____ LOT NO.: _____ | VACCINE: _____ SITE OF INJ.: _____ LOT NO.: _____ | |
| EXP. DATE: _____ RT OF ADMIN: _____ MFR: _____ | EXP. DATE: _____ RT OF ADMIN: _____ MFR: _____ | |
| VIS VERSION: _____ DOSAGE: _____ | VIS VERSION: _____ DOSAGE: _____ | |

Please provide a copy of this form to your physician and/or healthcare provider for your permanent medical records.
WHITE – Administrative Copy **YELLOW** – Patient Copy