Annual Influenza & COVID19 Vaccine Consent Form-2023/2024

Section 1: Patient Information (please print and complete every section)

Patient Name (Last)	(First)	(M.I.)	**Patient DOB:**	
Parent/Guardian Name (Last)	(First)	(M.I.)	**Patient Age:**	**Pinon PCP:**
Address			**Patient/Guardian phone #**	
City	**CO**	**Zip**		
Name of medical insurance to be billed: (***must be completed even if we have your info on file***)			**Did you leave a copy for our file?** **Y / N**	

Section 2: Screening for FLU Vaccine Eligibility

The following questions will help us to know if you can get the seasonal influenza vaccine**.** Answering "yes" does not prevent you from being vaccinated, it means additional questions will be asked. **Please mark YES or NO for each question.**

		YES	NO
1. Is patient currently ill or have a fever?		☐	☐
2. Has patient received influenza (flu) vaccine before?		☐	☐
3. Has patient ever had a serious reaction to a previous dose of flu vaccine?		☐	☐
4. Has patient ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness)?		☐	☐

Section 3 : Screening for COVID Vaccine Eligibility

The following questions will help us to know if you can get the COVID19 vaccine**.** Answering "yes" does not prevent you from being vaccinated, it means additional questions will be asked. **Please mark YES or NO for each question.**

	YES	NO
1. How many doses of any COVID19 vaccine has patient received to date? Select below ___0 ___1 ___2 ___3 ___4		
2. Have you had a severe reaction to any vaccine or injectable therapy?	☐	☐
3. Is patient currently ill or have a fever?	☐	☐
4. Has patient ever had a serious reaction to a previous dose of COVID a vaccine?	☐	☐
5. Does patient have a history of myocarditis or pericarditis?	☐	☐
6. Was patients last COVID19 vaccination less than 8 weeks from today?	☐	☐
7. Was patients last COVID19 vaccine either Comirnaty or Spikevax 23/24 formula?	☐	☐

Section 4: Consent

CONSENT FOR VACCINATION:

By signing below, I consent to Pinon Family Practice administering the current vaccinations to me/my dependent. In addition, I read or have had explained to me and understand the Vaccine Information Statement(s) for the vaccine(s) that PFP is administering today. I have read and understand PFP Financial Policy and agree to all terms within. I understand that PFP will bill my insurance and I accept full financial responsibility if not paid/covered by my insurance.

Signature of Patient/Legal Guardian _____ Date:_____

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www.pinonfamilypractice.com

FOR ADMINISTRATIVE USE ONLY

Vaccine	Route	Date Dose Administered	Vaccine Site (RT/LT) (Arm/Thigh)	Temp	Lot Number / Exp Manufacturer – Sanofi	Name and Title of Vaccine Administrator – pertinent positives verified.
FLUZONE **6 mo – 64 YEARS** (multi-dose vial) .5 ml	IM	/ /			LOT: _____ EXP: _____	
HIGH DOSE FLUZONE **65+ only** (prefilled syringe) .5 ml	IM	/ /			LOT: _____ EXP: _____	
FLUZONE Pres-Free **6mo-64 years** (single dose syringe) .5 ml	IM	/ /			LOT: _____ EXP: _____	

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Vaccine	Route	Date Dose Administered	Vaccine Site (RT/LT) (Arm/Thigh)	Temp	Lot Number / Exp Manufacturer – Sanofi	Name and Title of Vaccine Administrator – pertinent positives verified.
COVID 12+ Comirnaty 23/24 formula .3 ml - SDV	IM	/ /			LOT: _____ EXP: _____	
COVID 6mo-4yr Pfizer 23/24 formula .3ml – 3DV (DILUTE)	IM	/ /			LOT: _____ EXP: _____	
COVID 5yr-11yr Pfizer 23/24 formula .3ml – SDV	IM	/ /			LOT: _____ EXP: _____	