Whitman County Public Health
Growing A Healthier Community.

- Personal & Family Health
- Community Health
- Environmental Health

PULLMAN
1205 SE Pro Mall Blvd #203
Pullman, WA 99163
509.332.6752

COLFAX
310 N Main Street #108
Colfax, WA 99111
509.397.6280

Sid's PHARMACY

Whitman County Community Clinic

Immunization Consent Form

Patient Information

Patient's Last Name	Patient's First Name	MI	Sex listed at Birth (M/F)	Birth Date (MM/DD/YYYY)

Address	City	State	Zip Code

10-Digit Phone Number	Patient's Email

Primary Care Provider (MD, DO, NP, PA)

Race - Check all that apply:

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Caucasian
- ☐ Other: _____

Ethnicity - Check one:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Insurance Information

☐ Uninsured ☐ Insured

Insurance Name	Group #	ID #

If insured please bring your card and photo ID. We will take a copy of your information to bill insurance. If insurance does not reimburse for the full cost of services or rejects the claim, you will NOT be responsible for any remaining balances.

Immunization(s) Requested

- ☐ 24-25 Influenza injectable
- ☐ 24-25 COVID-19

Receiving ONLY a Flu immunization Today?
Only complete the green section on the next page.

Receiving BOTH a Flu & COVID immunization Today?
Complete the green section AND yellow section.

→ Next Page

Pre-Immunization Checklist

Is the person to be immunized sick today?	☐ Yes	☐ No
Do you have allergies to medications, food, a vaccine component, or latex?	☐ Yes	☐ No
Has the person to be immunized ever had Guillain-Barre Syndrome?	☐ Yes	☐ No
Has the person to be immunized had a serious reaction to the influenza vaccine in the past?	☐ Yes	☐ No
Has the person to be immunized ever fainted or felt dizzy after receiving an immunization?	☐ Yes	☐ No

Additional COVID-19 Pre-Immunization Checklist Questions

How old is the person to be immunized? _____

Has the person to be immunized ever received a dose of COVID-19 Vaccine? ☐ Yes ☐ No

If yes, circle which vaccine product was administered:

Pfizer-BioNTech Moderna Janssen (Johnson & Johnson) Novavax

Another Product

If yes and the child is UNDER 5 years of age, *how many doses of the COVID-19 vaccine were administered?* _____

Check all that apply to the person to be immunized:

- ☐ Have any of the following long term health problems: lung, heart, or kidney disease, diabetes, asthma, cochlear implant, or spinal fluid leak.
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
- ☐ Have a history of myocarditis or pericarditis (inflammation of the heart)
- ☐ Have a compromised immune system or are taking medications that affect your immune system like steroids or anti-cancer drugs.
- ☐ Have had a seizure or a brain or other nervous system problem
- ☐ Have been sick with COVID-19 in the past 3 months

→ Next Page

Benefits & Risks

I have received the current vaccine information sheet. I have had the chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the vaccine. 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 authorized to make this request ("Ward").

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 Sid's Pharmacy and Whitman County Public Health, 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 Sid's Pharmacy 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.

Insurance

I am aware of the pharmacy's policy that billing insurance/Medicare on my behalf or my ward's behalf is a courtesy provided by them. I will not be responsible for any payments not covered by insurance. I understand that Medicare may pay part of the amount billed by the pharmacy or part of the Medicare allowable amount whichever is less. I recognize my obligation to forward payment to the pharmacy for any payment received by me due to them. Insurance Lifetime Authorization: I request payment under the medical insurance program be made to me or the pharmacy named above on any bills for service. I authorize the above-named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for the claim or any related Medicare claim. I further permit a copy of this authorization to be used in the place of the original.

Disclosure of Records

I understand the organization providing my or my ward's vaccine may be required to or may voluntarily disclose vaccine-related health information to my or my ward's primary care physician, insurance plan, health systems and hospitals, and state or federal registries or other public health authorities, for purposes of treatment, payment or health care operations. I also understand the organization providing my or my ward's vaccine will use and disclose my health information as described in its Notice of Privacy Practices which I may receive upon request.

Signature of Patient, Legal Guardian, or Authorized Representative

Printed Name of Patient, Legal Guardian, or Authorized Representative

*If signing as an **Authorized Representative**, please complete the sections below.*

Name of Patient

Physical Address for contact purposes Authorized Representative

The mental or physical problem, that does not allow the patient to sign, and the relationship on their behalf A physician or supplier's office cannot sign on behalf of a patient except under extraordinary circumstances. Please contact the Medicare Office if you need further details.

STOP

Administrative Record *(for pharmacy use only)*

Sid's Pharmacy

Date of Vaccination/ Date VIS Given	Pharmacy Name	Pharmacy Address

Vaccinator Signature	Vaccinator Name	Vaccinator Title

Influenza

Vaccine:		RT Of Admin:	
Exp. Date:		Dosage:	
VIS Version:		Lot #:	
Site Of Inj:		MFR:	

COVID-19

Vaccine:		RT Of Admin:	
Exp. Date:		Dosage:	
VIS Version:		Lot #:	
Site Of Inj:		MFR:	

Notes: