65+ COVID-19 / INFLUENZA VACCINE CONSENT FORM 2024-2025

NAME First/Last _____**Date of Birth**_____**Age**_____

Address _____**City** _____ **Zip Code**: _____

Phone_____ **Gender** Male Female **Physician/Provider**_____

- **Please check the vaccine(s) you wish to receive today:** ☐ **Flu** ☐ **COVID-19**

MEDICAL QUESTIONS – Please answer each question

Questions:	**YES**	**NO**
1. Do you have allergies to any ingredient included in vaccines? (latex, eggs, polyethylene glycol, polysorbate 80)	☐	☐
2. Have you had a serious reaction to a vaccine/injectable medication in the past?	☐	☐
3. Do you have history of any of the following conditions (Check all that apply):	☐	☐
☐ Guillain-Barre Syndrome (a temporary severe muscle weakness) ☐ Myocarditis or pericarditis ☐ Multisystem Inflammatory Syndrome (MIS-C or MIS-A)		
4. Do you have an immunocompromising condition due to any cause?	☐	☐
5. Are you sick today or running a fever?	☐	☐

SIGNATURE AND CONSENT for vaccination(s) as indicated above

I understand the benefits & risks of the influenza(flu) vaccine &/or COVID-19 vaccine and request that vaccines (as indicated above) be administered to me or to the person named below for whom I am authorized to make this request. I acknowledge the QR code (below) provides me with current Vaccine Information Sheet(s) & am aware of any possible side effects. I hereby assume any risks related to receiving the vaccine(s) & release Lewis Drug & its agents, staff, representatives, successors & assigns, & subrogates from any & all liability related, directly or indirectly, which may arise from having been given the indicated vaccine(s). If I have received the vaccine(s) in my vehicle or otherwise outside of the Lewis Drug facility, I acknowledge that Lewis Drug has recommended that I park and wait for 15 minutes after vaccination to ensure I don't evidence any adverse reactions.

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Signature of patient (REQUIRED) **Date**

FOR STAFF ONLY: Lewis Drug #_____ **or CLINIC**_____

Vaccine	**Date of Administration:**	**Site of Administration**	**Immunizer Signature/title:**
FLU		**Deltoid:** Left Right Other_____	
COVID		**Deltoid:** Left Right Other_____	

Iowa: Date record sent to PCP:_____

FLU Manufacturer - Vaccine	Lot Number	Expiration Date	VIS - Scan QR code below
Sanofi – **FluzoneHD TIV** PFS 2024-2025 **age 65+**			
Sanofi – **Flublok TIV** PFS 2024-2025 **age 18+**			
Seqirus – **Fluad TIV** PFS 2024-2025 **age 65+**			

COVID-19 Manufacturer - Vaccine	Lot Number	Expiration Date	VIS - Scan QR code below
Moderna – **Spikevax** PFS 2024-2025 **age 12+**			
Novavax – **Novavax** PFS 2024-2025 **age 12+**			
Pfizer – **Comirnaty** PFS 2024-2025 **age 12+**			