COVID-19 / FLU Standard VACCINE 2024-2025 CONSENT FORM

Lewis Pharmacies

NAME First/Last: ____________________ **Date of Birth:** ____________ **Age:** ______

Address: ____________________ **City:** ____________ **Zip Code:** ____________

Phone: ____________ **Gender:** Male Female **Physician/Provider:** ____________________

Vaccines I wish to receive today: ☐ FLU (Inactivated/Injectable) ☐ COVID-19

MEDICAL QUESTIONS – Please answer each question

		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)

		YES	NO
4.	Do you have an immunocompromising condition due to any cause?	☐	☐
5.	Are you pregnant?	☐	☐
6.	Are you younger than 18 years of age? If so, parent/guardian must sign below	☐	☐
7.	Are you sick today or running a fever?	☐	☐

SIGNATURE AND CONSENT

I understand the benefits & risks of the influenza(flu) vaccine &/or COVID-19 vaccine & request that one or both(as above) be given to me or to the person named below for whom I am authorized to make this request. I acknowledge the QR code 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. ☐ opt out of SDIIS submission

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Signature of patient OR parent/guardian authorizing vaccination (REQUIRED) **Date**

IF signing for a MINOR please print your name & indicate relationship **(REQUIRED)**: ____________________

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 Provided
GSK – **Fluarix TIV** PFS 24-25 **age 6m+**	TK3YE	06/30/2025	
Sanofi – **Flublok TIV** PFS 24-25 **age 18+**			
Seqirus – **Flucelvax TIV** PFS 23-24 **age 6m+**			

COVID-19 Manufacturer - Vaccine	Lot Number	Expiration Date	VIS Provided
Moderna – **Spikevax** PFS 24-25 **age 12+**			
Novavax – **Novavax** PFS 24-25 **age 12+**			
Pfizer – **Comirnaty** PFS 24-25 **age 12+**			