FLU / COVID-19 2025-2026 VACCINE CONSENT FORM (standard dose)

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	**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 ☐ Myocarditis or pericarditis ☐ Multisystem Inflammatory Syndrome (MIS-C or MIS-A)	☐	☐
4. When was your last COVID-19 vaccination? date:_____		
5. Do you attest to having an immunocompromising or underlying medical condition that puts you at high risk for COVID-19? *See back for listing of underlying conditions*	☐	☐
6. Are you pregnant?	☐	☐
7. Are you younger than 18 years of age? If so, parent/guardian must sign below	☐	☐
8. 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

_____

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	
COVID		**Deltoid:** Left Right	

FLU Manufacturer - **Vaccine**	Lot Number	Expiration Date	VIS - Scan QR code below
Seqirus – **Flucelvax TIV** PFS 2025-2026 **age 6mo+**			1/31/2025
GSK - **Fluarix TIV** PFS 2025-2026 **age 6mo+**	2NG23 3F7A5	6/30/2026	
Sanofi – **Flublok TIV** PFS 2025-2026 **age 9+**			

COVID-19 Manufacturer - **Vaccine**	Lot Number	Expiration Date	VIS - Scan QR code below
Moderna – **Spikevax** PFS 2025-2026 **age 12+**			1/31/2025
Moderna - **mNexspike** PFS 2025-2026 **age 12+**			
Novavax – **Nuvavoxid** PFS 2025-2026 **age 12+**			
Pfizer – **Comirnaty** PFS 2025-2026 **age 12+**			

2025-26 COVID Vaccines received U.S. FDA Approval on Aug 27, 2025 for:

- **Adults 65 and Older, and**
- **Individuals Ages 5 through 64 at Increased Risk for Severe COVID-19.**

Your attestation confirms that you understand the approval and agree that you qualify for a dose of 2025-2026 COVID-19 vaccine.

Underlying medical conditions determined by the CDC, that may indicate a patient could be at higher risk of experiencing severe outcomes of COVID-19. This list should not be used to exclude people with underlying conditions from recommended measures for prevention or treatment of COVID-19.

- **Asthma**
- **Cancer /** Blood cancers
- **Cerebrovascular disease** (**stroke,** cerebral aneurysms, carotid artery disease)
- **Chronic kidney disease**
- People receiving **dialysis**
- **Chronic lung diseases** limited to: Bronchiectasis, COPD (Chronic obstructive pulmonary disease), Interstitial lung disease, Pulmonary embolism, Pulmonary hypertension
- **Chronic liver diseases** limited to: Cirrhosis, Non-alcoholic fatty liver disease, Alcoholic liver disease, Autoimmune hepatitis
- Cystic fibrosis
- **Diabetes mellitus**, type 1 & type 2 or gestational diabetes
- **Disabilities**, including Down syndrome
- **Heart conditions** (such as heart failure, coronary artery disease, or cardiomyopathies)
- HIV (Human immunodeficiency virus)
- **Mental health conditions** limited to: Mood disorders, including depression, Schizophrenia spectrum disorders
- **Obesity** (BMI $\geq$30 kg/m^2 or $\geq$95th percentile in children)
- **Physical inactivity**
- **Pregnancy** and recent pregnancy
- Primary immunodeficiency
- **Smoking,** current and former
- Solid organ or blood stem cell transplantation
- Tuberculosis
- Use of **corticosteroids or other immunosuppressive** medications