VACCINE ENCOUNTER FORM

PATIENT INFORMATION

Name			Birthdate	Age
Phone	Address (Street, city, state, zip)			
Race ☐ Native American or Alaska Native ☐ Asian ☐ African American ☐ Pacific Island ☐ White ☐ Other				
Ethnicity Hispanic ☐ Yes ☐ No		Gender ☐ Male ☐ Female		
Insurance Name		ID (For uninsured patient please include driver's license number here)		
Rx Group	BIN		PCN	

COVID-19
☐ **SPIKEVAX (12+)**

INFLUENZA
☐ **QUADRAVALENT (8+)**
☐ **HIGH DOSE (65+)**

PNEUMONIA
☐ **PREVNAR 20**

SHINGLES
☐ **SHINGRIX (50+)**

TENTANUS, DIPTHERIA, PERTUSSIS
☐ **ADACEL [TDAP] (11+)**

RSV
☐ **AREXVY (60+)**

PREVACCINATION CHECKLIST

1. Are you feeling sick today? ☐ Yes ☐ No ☐ Don't Know

2. Have you ever had an allergic reaction to:

(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)

- **A component of a vaccine, including either of the following:**
  ☐ Yes ☐ No ☐ Don't Know
  - Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures**.**
  - Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids**.**

3**. Check all that apply to you:**

☐ Am a female between ages 18 and 49 years old
☐ Am a male between ages 12 and 29 years old
☐ Have a history of myocarditis or pericarditis
☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies**.**
☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum.
☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
☐ Have a bleeding disorder
☐ Take a blood thinner
☐ Have a weakened immune system (i.e., HIV infection, cancer, radiation treatment) or take immunosuppressive drugs or therapies
☐ Have a history of heparin-induced thrombocytopenia (HIT)
☐ Am currently pregnant or breastfeeding
☐ Have received dermal fillers
☐ History of Guillain-Barré Syndrome (GBS)
☐ Smoke cigarettes

Patient/Legal guardian signature ________________________________ Date ______________

Print name (if other than patient) ____

I have been given a copy and have read or had explained to me, the information contained in the Vaccine Information Statement(s) about the disease(s) and vaccine(s). Any questions I had were answered to my satisfaction. I understand the benefits and risk of the vaccine(s) and request that the vaccine(s) indicated be given to me or the person for whom I am authorized to make this request. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). Further, I acknowledge that I have been advised to remain near the vaccination location for at least 15 minutes after administration for observation by the administering provider. I certify that I have received a copy or been given the opportunity to read the Notice of Privacy Practices. I agree that the immunizations may be shared with schools, day care centers, health care providers, and others to verify immunization status, for public health studies, or when medically necessary. I hereby release the Salmon Pharmacy and their employees from all claims arising from such immunizations. Unless I provide Salmon Pharmacy with a signed opt-out form, I elect to participate fully in and consent to Salmon Pharmacy reporting my information to the immunization registry. I authorized Salmon Pharmacy to release my medical or other information to my healthcare professionals. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Salmon Pharmacy, its staff, agents and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed.

JURISDICTION AND VENUE The terms and conditions contained within this agreement shall be governed by the laws of the State of Utah and shall be construed and interpreted in accordance with those laws. Any action or proceeding brought by either party which is based upon or derived from, or in any way related to this agreement shall be brought in a court of competent jurisdiction within the state of Utah. The parties hereto consent to their personal jurisdiction of said court. I understand that my health insurance coverage could have certain restrictions and limitations. I agree to pay the full amount for all related charges, if they are not covered by my insurance for any reason. If I fail to pay for these services and charges within 90 days of receiving notice that the charges are not covered for any reason, my account will be turned over to a collection agency. I hereby expressly agree to pay all the costs of collection fees including an additional collection of 18%. I further agree to pay all court costs and attorney's fees should legal action become necessary. I understand that I will be charged the full cost of the vaccines if I do not pay today, and my insurance company does not cover the costs for any reason. I hereby request and authorize the Salmon Pharmacy to submit claims to my Medicaid, Medicare, and/or UCHD contracted insurances.

VACCINE ENCOUNTER FORM

To be filled out by the pharmacy…

COVID-19 - Primary Series	DOSE	SITE	LOT	# IN SERIES
☐ SPIKEVAX (12+)	0.5 mL	R / L		

INFLUENZA	DOSE	SITE	LOT
☐ QUADRAVALENT (8+)	0.5 mL	R / L	
☐ HIGH DOSE (65+)	0.7 mL		

PNEUMONIA	DOSE	SITE	LOT
☐ PNEUMOVAX 23	0.5 mL	R / L	
☐ PREVNAR 20	0.5 mL		

SHINGLES	DOSE	SITE	LOT	# IN SERIES
☐ SHINGRIX (50+)	0.5 mL	R / L		

TENTANUS, DIPTHERIA, PERTUSSIS	DOSE	SITE	LOT
☐ ADACEL (Tdap)	0.5 mL	R / L	

RSV	DOSE	SITE	LOT
☐ AREXVY	0.5 mL	R / L	

Immunizer Signature ____ Date ____________________________