PHARMACY USE ONLY
CLINIC: Pringle Morse
BILLING: Insurance

UNITED EMPLOYEES ONLY
TM #: N/A
STORE #: N/A

UNITED PHARMACY CLINICAL SERVICES
Onsite Clinic Consent Form

Patient Name: _____

D.O.B._____ Age: _____ ☐ M ☐ F

Address: _____ Ph #: _____
Street City State Zip

Please provide date when vaccine was last received: Flu: _____ *Pneumonia:* _____ *Shingles:* _____ *Tetanus:* _____

Screening Questionnaire: Please answer the questions by checking the boxes	**Yes**	**No**
Do you feel ill today (fever/cough or shortness of breath/diarrhea >3 days/vomiting)?		
In the last 14 days, have you had contact with a lab confirmed COVID-19 patient?		
Have you ever had a serious reaction to a vaccine, eggs, or latex? If yes, please list:		
For women: Are you pregnant or are you considering becoming pregnant in the next month? Breastfeeding?		

Informed Consent: Please read and sign.

I verify that I have answered these questions to the best of my knowledge. By my signature below, I consent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist employed by United Pharmacy and to be contacted at the number provided above regarding other immunizations for which I am due or eligible to receive. I also release United Supermarkets, LLC, and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting or arising from my receipt of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination and understand that I am obligated to pay for all products and services received. 2) I may be responsible for payment after the date of service if the product or service is billed to my medical benefit. 3) I am of legal age and authorized to execute this consent form or I am not of legal age and have obtained the signed consent of a parent or guardian. 4) I will immediately alert the pharmacist of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine. 5) I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects. 6) I have been advised that I should remain in the area for 15 minutes after the vaccination for observation. 7) I have been provided access to a copy of United Supermarket Pharmacy's Notice of Privacy Practices. I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") provided for the vaccine(s) to be administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). 8) This vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting by my pharmacy or its business associate to an immunization registry, which may share my immunization data with others, and to my primary care physician, the authorizing physician, or the local Department of Health, if applicable, and I authorize these disclosures.

Signature: _____ **Date:** _____

Primary Care Physician (if known): _____ **Fax:** _____

The Pharmacy provided immunization services to the patient named below at our immunization clinic. He/she identified you as his/her primary care provider. Per Texas State Board of Pharmacy rule (Title 22 part 15, (1)(B)) a pharmacy must notify the patient's primary care provider of an immunization. Please update the patient's chart to include the vaccination(s) below.

----------***For Pharmacy Use Only***----------

Vaccine Administered	Lot #	Exp. Date	Site (R/L)	VIS Version

Place RX Label(s) Below:

Administered By: _____