Dignity Health
Chandler Regional Medical Center
CRMC/Community Wellness
1955 W. Frye Rd. Chandler, Az. 85224

ADULT Consent for Vaccine

	FLU	COVID-19	

Please Initial Vaccine Requested

FIRST NAME:_____ **DATE OF BIRTH:**_____**AGE:**_____
LAST NAME:____ _____**MIDDLE NAME:**_____
GENDER/SEX:_____**PHONE:**_____
ADDRESS:_____**CITY:**_____**ZIP:**_____

Please mark which one applies: _____ I DO NOT have health insurance (Uninsured)
_____ I have health insurance that does NOT pay for this vaccine (Under insured)
_____ I have health insurance that covers this vaccine.

I have been given a copy of the **"Vaccine Information Sheet" for Influenza (flu) Vaccine dated 8/06/21 and or the recipient and Caregiver Fact Sheet for Covid** I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the Vaccine and request that it be given to me. I agree to have this vaccine recorded in the Arizona Immunization Information System.

Signature of person to receive vaccine:_____

Effective April 14, 2003 the law requires that **Chandler Regional Medical Center** give to a patient a copy of its Notice of Privacy Practices for Health Information. This notice describes how medical information about you may be disclosed and how you can get access to this information. We will give you a copy at the time of first treatment and, if we change our notice, thereafter at the next treatment visit. By signing below, you acknowledge receipt of such as the patient, the patient's personal representative, the patient's authorized agent, or an individual involved in the patient's medical care. **Signature of person to receive vaccine:** _____ **Date:**_____

PLEASE ANSWER THE FOLLOWING:

Do you have a fever or feel ill today	☐ **YES**	☐ **NO**	Do you have any allergies?	☐ **YES**	☐ **NO**
Have you ever had a serious reaction to a prior dose of vaccine or injectable medicine? _____	☐ **YES**	☐ **NO**	Are you allergic to eggs?	☐ **YES**	☐ **NO**
			Do you have a history of Guillain-Barre Syndrome (a neurological disorder)?	☐ **YES**	☐**NO**
Do you have a bleeding disorder or are you taking a blood thinner**?**	☐ **YES**	☐ **NO**	Have you received any blood or medication transfusions in the past12 months?	☐ **YES**	☐**NO**
Have you ever rec. a Covid-19 vaccine?	☐ **YES**	☐ **NO**			

DATE GIVEN VIS & admin	FUNDING	VACCINE	MANUFACTURER LOT/EXP	ROUTE	SITE	REVIEWED/ ADMINISTERED BY
		IIV4		**IM**		
		IIV4 HIGH DOSE		**IM**		
		COVID-19		**IM**		