PATIENT NAME:_____**DOB:**_____

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to Prism Health and the licensed healthcare professional administering the requested vaccine(s), as applicable, to administer the immunization(s) I have requested below.

- ☐ Meningococcal ACWY [MenACYW]
- ☐ Meningococcal B [MenB]
- ☐ Human Papilloma [9vHPV]
- ☐ Hepatitis B [HepB]
- ☐ Hepatitis A [HepA]
- ☐ Measles, Mumps, Rubella [MMR]
- ☐ Varicella (Chicken Pox) [VAR]
- ☐ Tdap 7yrs+
- ☐ DTaP <7yrs
- ☐ Haemophilus B [HIB]
- ☐ Pneumococcal Conjugate [PCV13]
- ☐ Polio [IPV]
- ☐ COVID-19 Moderna
- ☐ COVID-19 Pfizer
- ☐ Influenza [FLU]

I understand that it is not possible to predict all possible side effects or complications associated with receiving this vaccine. I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Vaccine Information Statement (VIS) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration.

On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors 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 above.

I understand that in consideration for my child's/ward's participation in the PROGRAM, and as evidenced by my signature below, I hereby release and hold harmless THE BOARD OF EDUCATION OF THE CITY OF CHICAGO, its members, trustees, agents, officers, contractors, volunteers and employees from any liability which may accrue to me or to my child/ward, for any and all losses, injuries, damages to me or my child/ward, both known and unknown, foreseen and unforeseen, arising in connection with my child's/ward's participation in the PROGRAM whether or not said losses, injuries, damages, or liabilities result in whole or part from the negligence of the BOARD OF EDUCATION OF THE CITY OF CHICAGO, its members, trustees, employees, officers, contractors, volunteers, agents, or representatives.

I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State

PATIENT NAME:_____**DOB:**_____

HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Centers for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I understand that, depending on my state's law, I may need to specifically consent, and, to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies, State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws or federal law may permit certain disclosures of my vaccination information to or through the State HIE or to Government Agencies as required or permitted by law.

I further authorize the applicable Provider to: (a) release my medical or other information, including any communicable disease (including HIV) and mental health information, to, or through, the State HIE or Government Agencies to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice.

Prism Health may contact me, including by autodialed and prerecorded calls and texts, at any time, using the contact information provided in my patient record regarding health and safety matters, such as vaccine reminders.

Patient/Parent/Guardian Signature: _____Date:_____

Address:_____City, State, Zip_____

CLINICIANS: Please remember to keep the written consent forms in the tech binder and a digital record of each page for upload to PHL records.

PATIENT NAME:_____ **DOB:**_____

PRISM HEALTH LAB

Individual Screening Form For Parents/Guardians/Patients 18+

SCAN TO REGISTER ONLINE

prism.org/now | 1 (800) 325-1812

	Yes	No	Don't Know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
9. Does the child have a parent, brother, or sister with an immune system problem?	☐	☐	☐
10. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
11. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
13. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

Reviewed by:_____ **Date:**_____

For office use only:

PRISM
HEALTH LAB
WE CARE FOR OUR COMMUNITY
Prism.org | (800) 325-1812

PATIENT NAME:_______________________________**DOB:**______________________

IMMUNIZATION RECORD

NAME OF VACCINE: ____
VACCINE MANUFACTURER: ____
LOT NUMBER: ____
EXPIRATION DATE: ____
ADMINISTRATION SITE: ______LA__RA__LT__RT_______IM__SQ________IN_________

NAME OF VACCINE: ____
VACCINE MANUFACTURER: ____
LOT NUMBER: ____
EXPIRATION DATE: ____
ADMINISTRATION SITE: ______LA__RA__LT__RT_______IM__SQ________IN_________

NAME OF VACCINE: ____
VACCINE MANUFACTURER: ____
LOT NUMBER: ____
EXPIRATION DATE: ____
ADMINISTRATION SITE: ______LA__RA__LT__RT_______IM__SQ________IN_________

NAME OF VACCINE: ____
VACCINE MANUFACTURER: ____
LOT NUMBER: ____
EXPIRATION DATE: ____
ADMINISTRATION SITE: ______LA__RA__LT__RT_______IM__SQ________IN__________

NAME OF VACCINE: ____
VACCINE MANUFACTURER: ____
LOT NUMBER: ____
EXPIRATION DATE: ____
ADMINISTRATION SITE: ______LA__RA__LT__RT_______IM__SQ________IN_________

PROVIDER NAME (MD,DO, PA,ANP,RN):________________________**DATE:**__________

ADMINISTERED BY:____

CLINICIANS: Prior to releasing this form to the patient, please remember to keep a record for upload to PHL records.