BOOMER SOLUTIONS
A GUARDIAN PHARMACY

5415 S 125th E Ave Tulsa, OK 74146
310 S 1st Eufaula, OK 74432

Vaccination Consent & Release

Name:		Date of Birth:		Age:	
Facility Name:	Saint SImeon's				
Address and Phone:	3701 MLK Jr. Blvd Tulsa OK 74106 918-425-3583				

Medicare and Other Insurance Info (If Applicable)

Medicare ID#:		Effective Date of Part B:	
Name of Plan:		Plan ID#:	

Pre-Screening for Vaccine Eligibility

The following questions will help us determine which vaccines you may be given. If you answer "yes" to any question, it doesn't necessarily mean you should not be vaccinated	Yes	No
Have you ever had a serious reaction after receiving a vaccination? For example: anaphylaxis (severe allergic reaction), Guillain-Barre Syndrome (a type of temporary severe muscle weakness)		
Do you have any allergies to medications, foods, or vaccines? For example: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin, Yeast, or Latex?		
Do you have a history of seizure, brain problems, or nerve problems related to vaccination?		
Do you have a chronic health condition? (Heart, Lung, Kidney, or metabolic disease)		
Do you have an autoimmune condition or have taken immune suppressing medications? (Prednisone or other steroids, anticancer drugs, drugs for Rheumatoid Arthritis, Crohn's disease, or Psoriasis)		
For Women: Are you breastfeeding, pregnant, or planning pregnancy in the next month?		

**Please note – Those who have a moderate to severe illness with a fever should wait until they recover before getting vaccinated.*

Name & Title of Person Administering:		Date of Admin:	

FLU: (*If Applicable – Affix Label Here)

Manufacturer:		Lot#:		Exp Date:		SITE: □ Right Deltoid / □ Left Deltoid

Covid: (*If Applicable – Affix Label Here)

Dose:	□ **1st**	□ **2nd**	□ **Booster**			
Manufacturer:		Lot#:		Exp Date:		SITE: □ Right Deltoid / □ Left Deltoid

Consent For Vaccination:

I give my consent to Guardian Pharmacy, LLC, its affiliates, subsidiaries, and the licensed healthcare professional administering the vaccine, to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the vaccine(s) being administered and have received, read, and/or had explained to me the CDC's Vaccine Information Statement (VIS) or the FDA's Emergency Use Authorization (EUA) on the vaccine(s) I have elected to receive. I have had the opportunity to ask questions that were answered to my satisfaction. As with all medical treatments, I understand that there is no guarantee that I will not experience an adverse reaction from the vaccine. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless Guardian Pharmacy, LLC, and its affiliates, subsidiaries, staff, agents, successors, divisions, 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 requested and vaccine(s). I understand and agree that the information contained on this form may be shared with my medical provider(s), the State Health Division (SHD), my state's health information exchange, state immunization registries, and/or other state or federal government agencies as required by law, for the purpose of public health reporting, or for the purpose of care coordination. I further authorize Guardian Pharmacy to (a) release my medical or other information to Medicare, Medicaid, or other third-party payers as necessary to effectuate care or payment; (b) submit a claim to my insurer for the requested items and services; and (c) request payment of authorized benefits be made on my behalf to Guardian Pharmacy, LLC, its affiliates, or subsidiaries, with respect to the requested vaccine(s). I 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 immediately upon receipt of an invoice for the service. I agree to remain near the vaccination location for approximately 15-30 minutes after administration for observation.

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SIGNATURE of Resident/Responsible Party: ______________________________________Date:_____________________

Flu Vaccine Information: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf

COVID-19 Moderna fact sheet: https://eua.modernatx.com/covid19vaccine-eua/eua-fact-sheet-recipients.pdf

COVID-19 Pfizer fact sheet: https://www.fda.gov/media/153716/download