COSTCO PHARMACY

Immunization Consent Form

PATIENT'S LAST NAME: Hunt | PATIENT'S FIRST NAME: Sherry | MI: L | GENDER (M/F): F

ADDRESS: [redacted] AZ | CITY: [redacted] | STATE | ZIP

10-DIGIT PHONE NUMBER: [redacted] | MEDICARE ID NUMBER: [redacted] | BIRTH DATE (MM/DD/YYYY): 12-2-71

PRIMARY HEALTHCARE PRESCRIBER: D D AZ | PRESCRIBER ADDRESS: PO Box 52424 Phoenix AZ 85072 | PRESCRIBER PHONE/FAX: [redacted] | VACCINE REQUESTED: Flu

PRECAUTIONS AND CONTRAINDICATIONS (Please check yes or no for each question.)

1. Are you sick today? ☐ Yes ☒ No
2. Do you have allergies to medications, food or vaccines? ☐ Yes ☒ No
   Allergies _____
3. Have you ever had a serious reaction after receiving a vaccination? ☐ Yes ☒ No
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder? ☐ Yes ☒ No
5. Do you have cancer, leukemia, AIDS or any other immune system problem? ☐ Yes ☒ No
6. Do you take cortisone, prednisone, other steroids or anti-cancer drugs, or have you had X-ray treatments? ☐ Yes ☒ No
7. Have you had a seizure, brain or nerve problem? ☐ Yes ☒ No
8. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? ☐ Yes ☒ No
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? ☐ Yes ☒ No
10. Have you received any vaccinations in the past 4 weeks? ☐ Yes ☒ No
    If yes, what vaccines? _____
11. Are you allergic to eggs? ☐ Yes ☒ No
12. Are you allergic to latex? ☐ Yes ☒ No

ADVERSE REACTIONS

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of any vaccine causing serious harm, or death, is extremely small.

Local symptoms may include: slight tenderness, redness, itching or swelling at the site of injection.

Systemic symptoms may include: fever, malaise and muscle pain. Other systemic symptoms may occur infrequently. These reactions usually begin 6 to 12 hours after immunization and can persist for a few days. Immediate presumable allergic reactions such as hives, angioedema, allergic asthma or systemic anaphylaxis occur rarely after immunization. These reactions may result from hypersensitive reactions in people with severe egg allergy, and such people should not be given certain vaccines that contain eggs. People with documented immunoglobulin E (IgE)-mediated hypersensitivities to eggs or any other vaccine components, including thimerosal, may also be at increased risk of reactions from immunizations.

In the case of a severe reaction such as a high fever, behavior changes or flu-like symptoms that occur after vaccination, see a doctor right away. Signs of an allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, or dizziness within a few minutes to a few hours after the shot.

ADMINISTRATIVE RECORD FOR PHARMACY USE ONLY

VACCINE: Afluria	EXPIRATION DATE: 6/14	VACCINE:	EXPIRATION DATE:	VACCINE:	EXPIRATION DATE:
VIS VERSION: 7/26/13	SITE OF INJECTION: LA	VIS VERSION:	SITE OF INJECTION:	VIS VERSION:	SITE OF INJECTION:
MANUFACTURER: CSL	DOSAGE: 0.5ml	MANUFACTURER:	DOSAGE:	MANUFACTURER:	DOSAGE:
LOT NUMBER: 37449241	ROUTE OF ADMIN: IM	LOT NUMBER:	ROUTE OF ADMIN:	LOT NUMBER:	ROUTE OF ADMIN:

PAYMENT INFORMATION FOR PHARMACY USE ONLY

VACCINE FEES | TOTAL CHARGE

"I have read the adverse reactions associated with the administration of vaccines. A copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization(s) or the receipt of the immunization(s) by the person named below for whom I am the legal guardian ('Ward'). My medical record may be shared with my physician or other healthcare provider and the medical record of my Ward may be shared with his/her physician or other healthcare provider. I am requesting that the immunization(s) be given to me or my Ward. I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives and assigns, hereby release Costco, and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt by my Ward of this or these immunization(s). Neither Costco nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. Costco will use and disclose your personal and health information or the personal and health information of your Ward, to treat you or your Ward, to receive payment of the care we provide, and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to you and your Ward's personal health information. I acknowledge that I have received a copy of the Notice of Privacy Practices."

Sherry Hunt
SIGNATURE LEGAL GUARDIAN

Sherry Hunt
PRINT NAME

10/14/13
DATE OF VACCINATION/DATE VIS GIVEN

PHARMACIST/PRESCRIBER SIGNATURE

PHARMACY NAME/ADDRESS

PLEASE PROVIDE A COPY OF THIS FORM TO YOUR PHYSICIAN AND/OR HEALTHCARE PROVIDER FOR YOUR PERMANENT MEDICAL RECORDS.

WHITE – ADMINISTRATIVE COPY YELLOW – PATIENT COPY

12AB1202 7/12

GLADHART FAMILY MEDICINE

Tuberculosis Skin Test Form

Healthcare Professional/Patient Name: Erin Balowski / Sheryl Hoyt

Testing Location: Rt forearm

Date Placed: 8/6/13 @ 10 AM

Site: ☒ Right ☐ Left

Lot #: C4285AA Expiration Date: Dec. 10 2015 NDC# 49281-752-21

Signature (administered by): EMBlack, CMA

☐ RN ☐ MD Other: CMA

Date Read (within 48-72 hours from date placed): 8/8/13 @1047

Induration (please note in mm): 0 mm

PPD (Mantoux) Test Result: ☒ Negative ☐ Positive

Signature (results read/reported by):

☒ RN ☐ MD Other: MA

*In order for this document to be valid/acceptable, all sections of this form must be completed.

Gladhart Family Medicine
820 Ainsworth Drive, Suite A
Prescott, AZ 86301
928-777-9800
Fax: 928-777-9797

GLADHART
FAMILY MEDICINE

820 Ainsworth Drive, Suite A • Prescott, Arizona 86301 • (928) 777-9600 • Fax (928) 777-9797

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

Patient Name: Sheryl Hoyt Insurance ID: XBP850729586

Provider: Gregg R Gladhart, MD

Your provider has recommended that you receive the following medical service:

TB Skin test (RT forearm)
NDC # 49281-752-21
Lot C4283AA
Exp. 12-10-2015

EMB

Your insurance may not pay for these services if they determine that the services are experimental under their medical policy guidelines.

The purpose of this form is to help you make an informed choice about whether you want to receive these services, knowing that you may have to pay for them yourself.

CHOOSE ONE OPTION; SIGN AND DATE

- o YES, I want the services listed above, but I also want my insurance for an official decision on payment. If my insurance does pay, we will refund any payments you made to us, less co-pays or deductibles. If my insurance dos not pay I am responsible for payment.
- o YES, I want the services listed above, but do not bill my insurance. I may be asked to pay now, as I am responsible for payment.
- o NO, I do not want the services listed above. I understand that, with this choice, I am not responsible for the payment.

X Sheryl Hoyt 8/16/13

Signature of Patient or person acting on patient's behalf Date

Vaccine Administration Record for Adults

Patient name: Sherryl Hoyt
Birthdate: 10-2-71
Chart number: _____

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Update the patient's personal record card or provide a new one whenever you administer vaccine.

Vaccine	Type of Vaccine* (generic abbreviation)	Date given (mo/day/yr)	Route	Site given (RA, LA)	Vaccine		Vaccine Information Statement		Signature/ initials of vaccinator
					lot #	mfr.	Date on VIS§	Date given§	
Tetanus and Diphtheria (e.g., Td)	DTaP	2-7-12	IM	RA	04305BA	sanofi	5-17-07	2-7-12	
			IM						
			IM						
			IM						
			IM						
Hepatitis A† (e.g, HepA, HepA-HepB)			IM						
			IM						
			IM						
Hepatitis B† (e.g., HepB, HepA-HepB)	HepB 1st vaccine	1-26-12	IM	LA	BHBYB94258	merck	2-1-13	1-26-12	
	HepB 2nd inject	2-27-12	IM	LA	AHBVC034AA	merck	2-1-13	2-27-12	
	HepB 3rd inj	7-27-12	IM	RA	AHBVC034AA	merck	2-1-13	7-27-12	
Measles, Mumps, Rubella (MMR)			SC						
			SC						
Varicella (Var)			SC						
			SC						
Pneumococcal** PPV)			IM•SC						
			IM•SC						
Influenza (Flu)			IM						
			IM						
			IM						
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			IM						
Other									
Other									

Dtap 1-6-14

Gregg Gladhart, MD
820 Ainsworth Drive, Suite A
Prescott, AZ 86301
928-777-9600
Fax: 928-777-9797

*Record the generic abbreviation for the type of vaccine given (e.g., PPV, HepA-HepB), *not* the trade name.

For combination vaccines, fill in the row for each individual antigen composing the combination.

§Record the publication date of each VIS as well as the date it is given to the patient. According to federal law, VISs must be given to patients before administering each dose of Td, MMR, varicella, or hepatitis B vaccine.

** Some high-risk patients need a one-time revaccination with pneumococcal polysaccharide vaccine (PPV).

www.immunize.org/catg.d/p2023h.pdf • Item #P2023 (5/03)

PATIENT: Sheryl Hoyt

DATE: 1/26/12 TIME: 1145am

PATIENT CONSENT FORM

1. **Name of Procedure:** I, Sheryl Hoyt (patient or guardian name) give consent for Gregg R. Gladhart, MD and any other assistants, he chooses to perform this procedure: Hepatitis B Vaccine given Im (L) Deltoid 1st in the series
I understand the reason for the procedure is: Immunization.

2. **Risks/Dangers:** I understand that any procedure may have risks and dangers that can include: infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions, pneumonia, and possibly death. Some other risks or dangers of this kind of procedure are:

   _____

   _____.

3. A doctor or specially trained nurse will give me medicine to keep me from feeling the pain the surgery. This is called anesthesia. The medicine could make me relax or sleep. The medicine could cause problems. I could possibly even die. The doctor or specially trained nurse will decide what medicine to give me. I give my permission for any medicines expect for these: Flu Influenza.
4. If my physician finds any unexpected condition at the time of surgery, I give permission for him or her to do whatever treatments or procedures are necessary except I don't want:
   None.
   (If nothing, write none)
5. **I understand that no one can promise or guarantee that the operation or procedure will cure me or provide the expected outcome.**
6. I have read and completely understand this consent form. My questions have been answered. I have no more questions.

Do not sign unless you have read and thoroughly understand this form.

By signing this form, I am stating that I have read, and understand, consent and agree to the above.

X Sheryl Hoyt — 1-26-12 — 11:00

PATIENT/LEGAL REPRESENTATIVE — Date — Time/AM-PM

[signature] — 1-26-12 — 1145

WITNESS' SIGNATURE — Date — Time/AM-PM

PHYSICIAN DECLARATION: I have explained the contents of this document with the patient and have answered all the patient's questions. To the best of my knowledge, the patient has been adequately informed. The patient has consented.

[signature] — 1/26/12 — 1145

PHYSICIAN'S/ NURSE'S SIGNATURE — **Date** — **Time/ AM-PM**

GLADHART FAMILY MEDICINE
820 AINSWORTH, SUITE A
PRESCOTT, AZ 86301
PH (928) 777-9600 FAX (928) 777-9797

Health Information Summary for: *HOYT, SHERRYL (ID: HOYSH000)*

Printed on February 28, 2012 at 8:00 AM, covering February 27, 2012

Your Provider:

Gregg R. Gladhart MD

Vital Signs:

	February 27, 2012 at 08:31 AM
Weight	128 lbs
Visual Acuity Both	AL MA
Temperature	98.2 F
Blood Pressure	102/62
Smoking	Never
Respirations	16
Pulse	82
Oximetry	98 %
Height	5'1.8"

Procedures Performed or Noted:

HEP B VACCINE, ADULT

Orders Placed:

Hepatitis B Adult

Immunizations:

HEPATITIS B		
Date Given	**Physician/Clinic**	**DOSE**
02/27/2012	Gregg Gladhart MD/GLADHART FAMILY MEDICINE	1mL

Noted Allergies:

NKDA

Note: This summary may contain notes, lab results, or other reports that have not yet been signed or reviewed by your provider.

GLADHART FAMILY MEDICINE
820 AINSWORTH, SUITE A
PRESCOTT, AZ 86301
PH (928) 777-9600 FAX (928) 777-9797

Health Information Summary for: *HOYT, SHERRYL (ID: HOYSH000)*

Printed on February 8, 2012 at 9:32 AM, covering February 07, 2012

Your Provider:

Gregg R. Gladhart MD

Procedures Performed or Noted:

IMMUNIZATION ADMINISTERED
DTAP VACCINE

Immunizations:

DTAP		
Date Given	**Physician/Clinic**	**DOSE**
02/07/2012	Gregg Gladhart MD/GLADHART FAMILY MEDICINE	0.5mL

Noted Allergies:

NKDA

Current Medications:

ON NO MEDICATIONS, , for - days

Note: This summary may contain notes, lab results, or other reports that have not yet been signed or reviewed by your provider.

LabCorp
Laboratory Corporation of America

LabCorp Willow Creek
990 Willow Creek Road
Prescott, AZ 86301-1640
Phone: 602-454-8000

Specimen Number	Patient ID	Control Number	Account Number	Account Phone Number	Route
016-666-2615-0		BAP02702360	02702360	928-717-0724	00

Patient Last Name	Account Address
HOYT	Prescott Health Clinic PLLC
Patient First Name: SHERRYL / Patient Middle Name	1003 Division St Ste 2
Patient SS# / Patient Phone / Total Volume	PRESCOTT AZ 86301
Age (Y/M/D): 40/03/14 / Date of Birth: 10/02/71 / Sex: F / Fasting: No	
Patient Address	Additional Information: UPIN: S43628

Date and Time Collected	Date Entered	Date and Time Reported	Physician Name	NPI	Physician ID
01/16/12 16:15	01/16/12	01/19/12 09:27ET	BAST , T	1760682843	

Tests Ordered: Measles/Mumps/Rubella Immunity; Varicella-Zoster V Ab, IgG

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Measles/Mumps/Rubella Immunity					
Rubella Antibodies, IgG	13		IU/mL		01
			Non-immune	<5	
			Equivocal	5 - 9	
			Immune	>9	
Rubeola Ab, IgG, EIA	2.81	High	index	0.00 - 0.90	02
			Negative	<0.91	
			Equivocal	0.91 - 1.09	
			Positive	>1.09	
Presence of antibodies to Rubeola is presumptive evidence of immunity except when active infection is suspected.					
Mumps Abs, IgG	3.40	High	index	0.00 - 0.90	02
			Negative	<0.91	
			Equivocal	0.91 - 1.09	
			Positive	>1.09	
Presence of antibodies to Mumps is presumptive evidence of immunity except when active infection is suspected.					
Varicella-Zoster V Ab, IgG					
Varicella Zoster IgG	1.77	High	index	Immune >1.09	02
			Nonimmune	<0.91	
			Equivocal	0.91 - 1.09	
			Immune	>1.09	

01	PD	LabCorp Phoenix Dir: Frank Ryan, PhD 3930 E Watkins Suite 300, Phoenix, AZ 85034-7251
02	BN	LabCorp Burlington Dir: William F Hancock, MD 1447 York Court, Burlington, NC 27215-3361

For inquiries, the physician may contact Branch: 928-778-7823 Lab: 602-454-8000