Stop & Shop Pharmacy Vaccine Informed Consent

Store Number:	Appointment Date:	Appointment Time:	Confirmation Number:

First Name:	Middle Name:	Last Name:	Date of Birth: _____ Age: _____ Gender: _____

Address: _____ City: _____ County: _____ State: _____ Zip: _____

Email Address: _____ Home Phone: _____ Mobile Phone: _____

Primary Care Provider: _____ Provider Phone Number: _____

Provider Address: _____ Provider Fax Number: _____

I do not currently have a Primary Care Provider ☐

Indicate your race by choosing one of the following options:

☐ Asian ☐ Black/African American ☐ White ☐ Other

☐ Native Hawaiian/Other Pacific Islander ☐ Unknown

☐ American Indian/Alaskan Native

Indicate your ethnicity by choosing one of the following options:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

☐ Unknown

Medicare B Information

Complete this Section if you are Medicare eligible/65+

(This is the information found on your red, white, and blue card)

Medicare B #	
Last 4 # of SSN	
Name as it appears on card	

NJ Only) I authorize the pharmacist to send copies of my vaccine documents to my primary care provider. Failure to select one of these boxes will result in the vaccine documents being sent to my primary care provider, if known, as state laws and regulations require for my state.

YES ☐ **NO** ☐

(NY Only)

Mother's maiden name: _____

Insurance Information *(Please record all information as vaccinations can be billed in multiple ways)*

	Pharmacy Insurance Card	Medical Insurance Card
Insurance Name/Payer ID#		
Cardholder ID #		
RX BIN #		N/A
RX PCN #		N/A
Group #		
Cardholder Info: (if not the patient above)	Name: _____ DOB: _____ Relationship to Cardholder: _____	

Uninsured only- Complete this section if you do not have any private or government funded pharmacy or medical insurance

☐ I attest that I do not have any medical or pharmacy insurance coverage

Driver's License or State ID Information ***(For billing purposes only)***	State: _____ ID#: _____

Pharmacist Use ONLY Section

Admin Date	Dose #	Lot #	Exp Date	Product & Manufacturer	Dose	Injection Site	EUA/VIS Revised Date	EUA/VIS Provided Date
					mL	IM/SQ L/R PLUA/DELTOID		
					mL	IM/SQ L/R PLUA/DELTOID		
					mL	IM/SQ L/R PLUA/DELTOID		
					mL	IM/SQ L/R PLUA/DELTOID		

Screening Questionnaire. Ask or contact the pharmacist for any assistance. **Patient Name: _____ DOB: _____**	**Yes**	**No**
Check any condition/age group below that applies to you so we may screen for needed vaccinations: **Diabetes ☐ Asthma ☐ Smoker ☐ Heart Condition ☐ Lung Condition ☐ 50 or older ☐ 65 and older ☐**		
Have you had the following vaccinations? **Influenza ☐ Pneumonia ☐ Meningitis ☐ Shingles ☐ Tetanus ☐ Whooping Cough ☐ Hepatitis ☐ Covid-19 ☐**		
1. What vaccine or vaccines are you interested in receiving today? Check all that apply. ***A pharmacist will review your answers to determine what vaccines you are eligible to receive today.*** **COVID-19 ☐ Flu ☐ Shingles ☐ Tetanus/Tdap ☐ Pneumonia ☐ Other: _____**		
2. Have you received any vaccines in the last 28 days? If yes, what product did you receive and when? **Product 1: _____ Date: _____ Product 2: _____ Date: _____**	☐	☐
3. Have you ever received a dose of COVID-19 vaccine? If yes, what product did you receive and when? Moderna ☐ Pfizer ☐ Janssen (Johnson & Johnson) ☐ Another product: _____ Date: _____	☐	☐
4. Do you feel sick today? (For example: a cold, fever, or acute illness)	☐	☐
5. Have you taken any antivirals (i.e. Tamiflu, valacyclovir) within the past 48 hours?	☐	☐
6. Have you ever fainted after receiving a vaccine or after having blood drawn?	☐	☐
7. Have you ever had a severe reaction to any vaccine which required medical care?	☐	☐
8. Have you ever had an allergic reaction to any of the following: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)*		
A previous dose of COVID-19 vaccine	☐	☐
A component of the COVID-19 vaccine, including either of the following: o *Polyethylene glycol (PEG),* which is found in some medications, such as laxatives and preparations for colonoscopy procedures o *Polysorbate,* which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐
A vaccine (other than a COVID-19 vaccine) or an injectable medication?	☐	☐
Food, pets, venom, environmental, or oral medication? *(ex. eggs, yeast, preservatives, phenol, thimerosal, streptomycin, neomycin, gelatin, latex, bovine protein)*	☐	☐
9. Have you ever been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?	☐	☐
10. Do you have a history of myocarditis or pericarditis?	☐	☐
11. Do you have dermal fillers?		
12. Have you received passive antibody therapy (monoclonal antibodies/convalescent serum) as treatment for COVID-19, or have you received Immune (gamma) Globulin, or a blood/plasma transfusion in the last year? When was your last dose?	☐	☐
13. Do you have a bleeding disorder, take a blood thinner, or have a history of Heparin Induced Thrombocytopenia (HIT)?	☐	☐
14. Do you, or anyone in your home, or anyone you take care of, have a weakened immune system caused by something such as HIV/AIDS, or cancer or take immunosuppressive drugs or therapies? This includes being treated with prednisone, other steroids, weekly injections, anticancer drugs, or radiation.	☐	☐
15. Do you have a long-term health problem with heart, lung, kidney, diabetes, asthma, blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long term aspirin therapy?	☐	☐
16. Have you had a seizure, brain, or any other neurological disorder, or have you had Guillain-Barré Syndrome, a condition which causes paralysis?	☐	☐
17. If <17 years of age: Are you currently taking aspirin or any aspirin-containing products?	☐	☐
18. Are you pregnant, planning to become pregnant, or breastfeeding?	☐	☐

Pharmacist Use ONLY Section
Pharmacist Notes:
I have reviewed the patient's state attestation documents (if applicable in my state) RPh Initials: ____
Copy sent to provider: YES □ NO □ Certificate of Immunization given to patient: YES □ NO □
Registry checked to confirm dose number/product: YES □ NO □ Date: _____ Product: _____
I have reviewed the Vaccine Screening Questionnaire to assess the patient for potential contraindications and precautions to the vaccines being administered today. I have confirmed vaccine requested is indicated for the patient. RPh Initials: _____
Pharmacist/Intern/Technician Name: _____ Title: _____ Date: _____
Pharmacist/Intern/Technician Signature: _____ NPI: _____ Lic #: _____
Location of Pharmacy/Administration: _____ Phone: _____

Informed Consent:

Patient Name: _____ DOB: _____

Emergency Use Authorization: The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same time of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Consent: I certify that I am: (i) the Patient and at least 18 years of age; or (ii) the patient's personal representative. I consent to, or give consent for, the administration of the vaccine(s) marked on this consent form by a Stop & Shop pharmacist. Where applicable and accepted by state regulations, I consent to my vaccine being administered by a Stop & Shop pharmacy intern or technician. I acknowledge I have the right to ask for a copy of the Stop & Shop Notice of Privacy Practices. I have read, or have had read to me, the Vaccine Information Statement (VIS) or EUA Fact Sheet for the vaccines indicated on this form. For COVID-19 Vaccine: I have been provided and have read, or had explained to me, the patient fact sheet corresponding to the COVID-19 vaccination given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand that if a vaccine requires multiple doses, multiple doses of the vaccine will need to be administered (given). I have been given the opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand the benefits and risk of vaccination, and I voluntarily assume full responsibility for any reactions that may result. I have had the opportunity to ask questions, all of which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I understand that I should remain in the vaccine administration area for at least 15 minutes and may need to remain for 30 minutes (if required based on answers to screening questions above) after the vaccination to be monitored for potential adverse reactions. I consent to the emergency administration of epinephrine and/or diphenhydramine, if necessary, to treat an adverse event following vaccine administration. I understand if I experience side effects that I should do the following: call the pharmacy, contact a doctor and/or call 911. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my own expense. I understand that any monies or benefits for administration the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I understand that Stop & Shop Pharmacy may be required to or may voluntarily disclose my health information to my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, educational institutions, manufacturers, and/or state or federal registries, for purposes of treatment, payment, or other health care operations (such as administration or quality assurance). I also understand that Stop & Shop Pharmacy will use and disclose my health information as set forth in the Notice of Privacy Practices, a copy of which can be obtained in-store, online, or by requesting a paper copy from the pharmacy). I hereby release Stop & Shop Pharmacy and its parent, subsidiary and affiliates, and its officers, employees, and agents, respectively, from any and all liability that might arise from this vaccination on behalf of me, my heirs, and personal representatives**.**

Patient Name (Printed): _____

X_____ Date: _____

Signature of Patient or Patient's Personal Representative**A Personal Representative is someone who has legal authority to make healthcare decisions on the behalf of the patient.*

Patient Guardian (please print): _____Guardian Type: _____