Giant/Martins Pharmacy Vaccine Informed Consent				
Store Number:	Appointment Type:	Appointment Date:		Confirmation Number:
Name:		Date of Birth:	Age:	Gender:
Address:	City:	County:	State:	Zip:
Email Address:		Home Phone:		Mobile Phone:
Primary Care Provider: Provider Address:		Provider Phone Number: I do not currently have a Primary Care Provider ☐		
Race: ☐ Asian ☐ Black/African American ☐ White ☐ Other ☐Unknown ☐Native Hawaiian/Other Pacific Islander ☐American Indian/Alaskan Native		**Ethnicity:** ☐Unknown ☐Hispanic or Latino ☐Not Hispanic or Latino		

Screening Questionnaire. Ask or contact the pharmacist for any assistance.	**Yes**	**No**
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. *If interested in COVID vaccine please make that your primary appointment, as products and locations may vary** ☐ COVID-19 ☐ Flu ☐ Shingles ☐ Tetanus/Tdap ☐ Pneumonia ☐ Other(s):		
Do you feel sick today (For example: a cold, fever, or acute illness?)	☐	☐
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 1:* *Date 2 (if applicable):* *Date 3 (if applicable):*	☐	☐
Do you have a history of allergic reaction or allergies to vaccines, medications (including injectable therapy), latex, or foods? Examples: COVID-19 vaccine, polyethylene glycol (PEG), polysorbate, eggs, yeast, preservatives, phenol, thimerosal, streptomycin, neomycin, gelatin, latex, bovine protein *(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.)*	☐	☐
Have you ever had a severe reaction to any vaccine which required medical care including fainting or feeling dizzy?	☐	☐
Have you received a vaccine in the past 4 weeks?	☐	☐
Have you ever been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?	☐	☐
Do you have a history of myocarditis or pericarditis?	☐	☐
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?*	☐	☐
Do you have a chronic health condition such as heart disease, chronic lung disease, chronic kidney disease, diabetes, asthma, blood disorder, complement component deficiency, no spleen, a cochlear implant, or spinal fluid leak?	☐	☐
Have you had a seizure, brain, or any other neurological disorder, or have you had Guillain-Barré Syndrome, a condition which causes paralysis?	☐	☐
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.	☐	☐
Have you taken any antivirals (i.e. Tamiflu, valacyclovir) within the past 48 hours?	☐	☐
Do you have a bleeding disorder, take a blood thinner, take aspirin or any aspirin-containing products or have a history of Heparin Induced Thrombocytopenia (HIT)?	☐	☐

Patient Name:	Date of Birth:	
Are you pregnant, planning to become pregnant, or breastfeeding?	☐	☐
Do you have dermal fillers?	☐	☐

For emergency use only, please indicate your weight category <33lb ☐ 34-66lbs ☐ >66lbs ☐

Check any condition below that applies to you so we may screen for other needed vaccinations:

Diabetes ☐ Asthma ☐ Smoker ☐ Heart Condition ☐ Lung Condition ☐ 50 or older ☐

Have you had the following vaccinations?

Influenza ☐ Pneumonia ☐ Meningitis ☐ Shingles ☐ Tetanus ☐ Whooping Cough ☐ Hepatitis ☐ Covid-19 ☐

Medicare B #: Last 4 SSN: Name as it Appears on Card:	**Pharmacy Insurance Information** RX ID #: RX BIN: RX PCN: RX Group:

PHARMACIST USE ONLY

Admin Date	Vaccine	Dose #	Lot	EXP Date	BUD	Manufacturer	Injection Site: PLUA - Post Lateral Upper Arm – SQ Deltoid - IM	EUA/VIS Date	EUA/VIS Revised Date
							IM/SQ L/R Deltoid/PLUA		
							IM/SQ L/R Deltoid/PLUA		
							IM/SQ L/R Deltoid/PLUA		

Pharmacist/Intern/Technician Name: _____ Title: _____ Date: _____

PHARMACIST USE ONLY

Registry checked to confirm appropriate dose(s) number/product: YES □ NO □ Date: _____

Pharmacist Notes:

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: _____

Copy sent to provider: YES □ NO □
Certificate of Immunization given to patient: YES □ NO □
Next Dose Date:_____Next Dose Time: _____

Pharmacist/Intern/Technician Signature:_____NPI: _____

Location of Pharmacy/Administration:_____Phone: _____

Emergency Use Authorization: The FDA has made certain vaccines (ex. 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 Giant/Martins Pharmacist. Where applicable and accepted by state regulations, I consent to my vaccine being administered by a Giant/Martins pharmacy intern, or technician. I acknowledge I have the right to ask for a copy of the Giant/Martins 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 Giant/Martins 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 Giant/Martins 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 Giant/Martins 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.

Informed Consent	
Patient Name (printed):	Date of Birth:
Patient or Patient's Personal Representative Signature*: _____ **A Personal Representative is someone who has legal authority to make healthcare decisions on the behalf of the patient*	Date:
Patient Guardian Name (printed):	Guardian Type: