Stop & Shop Pharmacy Vaccine Informed Consent rev 10.2023

Store: Type: Date: Conf. #:

First Name:	Middle Initial:	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:	**Indicate your ethnicity by choosing one of the following options:**
☐ Asian ☐ Black/African American ☐ White ☐ Other ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ American Indian/Alaskan Native	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
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: _____

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.

Emergency Use Instructions: EUI provide information about emergency use of FDA-approved medical products that may not be included in or differ in some way from the information provided in the FDA-approved labeling (package insert).

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), EUI Instructions, 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, health care living facilities, 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: _____

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** ☐ **60 or older** ☐ **65 and older**		
Have you had the following vaccinations? ☐ **Influenza** ☐ **COVID-19** ☐ **RSV** ☐ **Pneumonia** ☐ **Shingles** ☐ **Tetanus** ☐ **Whooping Cough** ☐ **Hepatitis** ☐ **Meningitis**		
1. What vaccine(s) are you interested in receiving today (in addition to your scheduled vaccine)? Check all that apply. ***A pharmacist will review your answers to determine what vaccines you are eligible for. Availability is subject to change.*** ☐ **Updated Moderna COVID-19** ☐ **Updated Pfizer COVID-19** ☐ **Other COVID-19** ☐ **Flu** ☐ **RSV** ☐ **Shingles** ☐ **Tetanus/Tdap** ☐ **Pneumonia** **Other: _____**		
2. Have you received any vaccines in the past 4 weeks?	☐	☐
3. Have you received a COVID-19 vaccine? When was your last dose? _____	☐	☐
4. Did you bring your vaccination record card or other documentation?	☐	☐
5. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐
6. Do you feel sick today? (For example: a cold, fever, or acute illness)	☐	☐
7. Have you taken any antivirals (i.e., Tamiflu, valacyclovir) within the past 48 hours?	☐	☐
8. Have you ever fainted after receiving a vaccine or after having blood drawn?	☐	☐
9. Have you ever had a severe reaction to any vaccine which required medical care?	☐	☐
10. Do you have a history of allergic reaction or allergies to vaccines, vaccine components, medications (including injectable therapies), 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.*	☐	☐
11. Have you ever been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A), myocarditis, or pericarditis?	☐	☐
12. Are you receiving a hematopoietic cell transplant (HCT) or CAR-T cell therapies?	☐	☐
13. 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) or thrombosis with thrombocytopenia syndrome (TTS)?	☐	☐
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, organ transplant, 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 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?	☐	☐
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. Are you pregnant, planning to become pregnant, or breastfeeding?	☐	☐
18. For emergency use only, please indicate the patient's weight category: ☐ **<33lbs** ☐ **33-66lbs** ☐ **>66lbs**		

Patient Name: _____ **Date of Birth:** _____

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:**

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**	**Vaccine Name & Manufacturer**	**Dose**	**Injection Site**	**EUA/EUI/ VIS Revised Date**	**EUA/EUI/ 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		

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: _____