

### Stop & Shop Pharmacy Vaccine Informed Consent

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 (PCP): _____		PCP Phone: _____	
PCP Address: _____		PCP Fax: _____	
I do not currently have a Primary Care Provider <input type="checkbox"/>			
<b>Indicate your race by choosing one of the following options:</b> <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> American Indian/Alaskan Native		<b>Indicate your ethnicity by choosing one of the following options:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
<b>NJ Only</b> 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. <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		<b>(NY Only)</b> Mother's maiden name: _____	

Informed Consent:	
<b>Patient Name:</b> _____	<b>DOB:</b> _____
<p><b>Emergency Use Authorization:</b> 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.</p>	
<p><b>Consent:</b> 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 &amp; Shop pharmacist. Where applicable and accepted by state regulations, I consent to my vaccine being administered by a Stop &amp; Shop pharmacy intern or technician. I acknowledge I have the right to ask for a copy of the Stop &amp; 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 &amp; 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 &amp; 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 &amp; 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.</p>	
Patient Name (Printed): _____	
X _____ Date: _____ Signature of Patient or Patient's Personal Representative* <i>A Personal Representative is someone who has legal authority to make healthcare decisions on the behalf of the patient.</i>	
<b>Patient Guardian (please print):</b> _____ <b>Guardian Type:</b> _____	

Screening Questionnaire. Ask or contact the pharmacist for any assistance.		Yes	No
Patient Name: _____ DOB: _____			
Check any condition/age group below that applies to you so we may screen for needed vaccinations: Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Smoker <input type="checkbox"/> Heart Condition <input type="checkbox"/> Lung Condition <input type="checkbox"/> 50 or older <input type="checkbox"/> 65 and older <input type="checkbox"/>			
Have you had the following vaccinations? Influenza <input type="checkbox"/> Pneumonia <input type="checkbox"/> Meningitis <input type="checkbox"/> Shingles <input type="checkbox"/> Tetanus <input type="checkbox"/> Whooping Cough <input type="checkbox"/> Hepatitis <input type="checkbox"/> Covid-19 <input type="checkbox"/>			
1. What vaccine or vaccines are you interested in receiving today? Check all that apply. <i>A pharmacist will review your answers to determine what vaccines you are eligible to receive today.</i> <i>*If you are interested in a COVID vaccine please make your primary appointment for this vaccine, as quantities and vaccines can vary by location</i> *COVID-19 <input type="checkbox"/> Flu <input type="checkbox"/> Shingles <input type="checkbox"/> Tetanus/Tdap <input type="checkbox"/> Pneumonia <input type="checkbox"/> Other: _____			
If receiving a COVID-19 vaccine, are you requesting to receive: Dose 1 <input type="checkbox"/> Dose 2 <input type="checkbox"/> Dose 3 (immunocompromised) <input type="checkbox"/> Booster Dose <input type="checkbox"/>			
2. Have you received any vaccines (not COVID-19) in the last 28 days? If yes, what product did you receive & when? Product 1: _____ Date: _____ Product 2: _____ Date: _____ Product 3: _____ Date: _____		<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever received a dose of COVID-19 vaccine? If yes, what product did you receive and when? Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another product <input type="checkbox"/> : _____ Date 1: _____ Date 2 (if applicable): _____ Date 3 (if applicable): _____ Date 4 (if applicable): _____		<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel sick today? (For example: a cold, fever, or acute illness)		<input type="checkbox"/>	<input type="checkbox"/>
5. Have you taken any antivirals (i.e. Tamiflu, valacyclovir) within the past 48 hours?		<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever fainted after receiving a vaccine or after having blood drawn?		<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had a severe reaction to any vaccine which required medical care?		<input type="checkbox"/>	<input type="checkbox"/>
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		<input type="checkbox"/>	<input type="checkbox"/>
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		<input type="checkbox"/>	<input type="checkbox"/>
A vaccine (other than a COVID-19 vaccine) or an injectable medication?		<input type="checkbox"/>	<input type="checkbox"/>
Food, pets, venom, environmental, or oral medication? (ex. eggs, yeast, preservatives, phenol, thimerosal, streptomycin, neomycin, gelatin, latex, bovine protein)		<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?		<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have a history of myocarditis or pericarditis?		<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have dermal fillers?		<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have a bleeding disorder, take a blood thinner, or have a history of Heparin Induced Thrombocytopenia (HIT)?		<input type="checkbox"/>	<input type="checkbox"/>
13. 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.		<input type="checkbox"/>	<input type="checkbox"/>
14. 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?		<input type="checkbox"/>	<input type="checkbox"/>
15. Have you had a seizure, brain, or any other neurological disorder, or have you had Guillain-Barré Syndrome, a condition which causes paralysis?		<input type="checkbox"/>	<input type="checkbox"/>
16. If <17 years of age: Are you currently taking aspirin or any aspirin-containing products?		<input type="checkbox"/>	<input type="checkbox"/>
17. Are you pregnant, planning to become pregnant, or breastfeeding?		<input type="checkbox"/>	<input type="checkbox"/>
18. For emergency use only, please indicate the patient's weight category: <33lbs <input type="checkbox"/> 33-66lbs <input type="checkbox"/> >66lbs <input type="checkbox"/>			

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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		
<input type="checkbox"/> 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/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		
<b>Pharmacist Notes:</b>								
I have reviewed the patient's state attestation documents (if applicable in my state) RPh Initials: _____								
Copy sent to provider: YES <input type="checkbox"/> NO <input type="checkbox"/> Certificate of Immunization given to patient: YES <input type="checkbox"/> NO <input type="checkbox"/>								
Registry checked to confirm dose number/product: YES <input type="checkbox"/> NO <input type="checkbox"/> 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: _____								