Stop & Shop Pharmacy Vaccine Informed Consent

FOR FLU VACCINES ONLY

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: _____

Provider Address: _____ Provider Fax: _____

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

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

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. 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 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 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: _____

FOR FLU VACCINES ONLY		
Screening Questionnaire. Ask or contact the pharmacist for any assistance. **Patient Name:** **DOB:**	**Yes**	**No**
1. Do you feel sick today? (For example: a cold, fever, or acute illness)	☐	☐
2. Have you taken any antivirals (i.e. Tamiflu, valacyclovir) within the past 48 hours?	☐	☐
3. Have you ever fainted after receiving a vaccine or after having blood drawn?	☐	☐
4. Have you ever had a severe reaction to any vaccine which required medical care?	☐	☐
5. 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 vaccine or an injectable medication?	☐	☐
Food, pets, venom, environmental, or oral medication? *(ex. eggs, yeast, preservatives, polyethylene glycol (PEG), phenol, thimerosal, streptomycin, neomycin, gelatin, latex, bovine protein)*	☐	☐
6. 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.	☐	☐
7. 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?	☐	☐
8. Have you had a seizure, brain, or any other neurological disorder, or have you had Guillain-Barré Syndrome, a condition which causes paralysis?	☐	☐
9. If <17 years of age: Are you currently taking aspirin or any aspirin-containing products?	☐	☐
10. Are you pregnant, planning to become pregnant, or breastfeeding?	☐	☐

Pharmacist Use ONLY Section

FOR FLU VACCINES ONLY

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

Pharmacist Notes:

Copy sent to provider: YES ☐ NO ☐ Certificate of Immunization given to patient: YES ☐ NO ☐

Registry checked? YES ☐ NO ☐ Notes:

I have reviewed the Vaccine Screening Questionnaire to assess the patient for potential contraindications and precautions to the vaccine 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: _____