Stop & Shop Pharmacy Vaccine Informed Consent Form

Name: _____ **Date of Birth**: ___/___/_____ **Age**: _____ **Gender**: _____

Street Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Phone: (_____) _____-_____

Primary Care Provider: _____ **Address**: _____

Vaccine(s) to be given today: _____ / _____ / _____

(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**

The following questions will help us determine your eligibility to be vaccinated today. If any questions are unclear, please ask for assistance.	**YES**	**NO**
Do you feel sick today or currently have a fever or infection?		
Are you allergic to any medications, foods, or vaccines? (i.e. eggs, yeast, preservatives, phenol, thimerosal, streptomycin, neomycin, gelatin, latex, bovine protein)		
Have you ever had a severe reaction to any vaccine which required medical care?		
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?		
Have you had a seizure, brain or any other neurological disorder, or have you had Guillain-Barré Syndrome, a condition which causes paralysis?		
Have you received Immune (gamma) Globulin or a transfusion of blood or plasma in the past year?		
Have you taken any antivirals (i.e. Tamiflu, valacyclovir) within the past 48 hours?		
Are you, anyone in your home, or anyone you take care of being treated with prednisone, other steroids, weekly injections, anticancer drugs or radiation?		
Do you, anyone in your home, or anyone you take care of have cancer, HIV/AIDS or any other immune deficiency disorder?		
If <17 years of age: Are you currently taking aspirin or any aspirin-containing products?		
For women: Are you pregnant, nursing, or planning a pregnancy in the next 3 months?		
Have you received any vaccinations in the past 4 weeks?		

Check any condition below that applies to you:

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

Have you received the following vaccinations?

☐Influenza ☐Pneumonia ☐Meningitis ☐Shingles (50 or older) ☐Tetanus ☐Whooping Cough ☐Hepatitis

I certify that I am: (i) the Patient and at least 18 years of age; (ii) the patient's personal representative. I consent to, or give consent for, the administration of the vaccine(s) marked below 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. 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) indicated below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I authorize the information to be forwarded to my primary care physician, authorizing physician or local Dept. of Health/registry, if applicable**. I agree to stay in the general area for 20 minutes after receiving my vaccination in case any immediate reactions occur**. I consent to the emergency administration of epinephrine and/or diphenhydramine, if necessary, to treat an adverse event following vaccine administration I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I hereby release Stop & Shop Pharmacy and its parent, subsidiary and affiliates, and its officers, employees and agents, respectively, from any & all liability that might arise from this vaccination on behalf of me, my heirs and personal representatives.

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.)*

FOR PHARMACIST USE ONLY

Admin Date/ VIS Given	**Vaccine**	**Vaccine Lot #**	**Exp Date**	**Manufacturer**	**Dose**	**Site of Injection** PLUA: Post Lateral Upper arm (SQ), Deltoid (IM)	**VIS Date**
						IM / SQ L / R Deltoid / PLUA	
						IM / SQ L / R Deltoid / PLUA	
						IM / SQ L / R Deltoid / PLUA	

-I have reviewed the Informed Consent Form to assess patient for potential contraindications and precautions to the vaccine(s) being administered today, and I have confirmed the vaccine(s) requested is/are indicated for this patient. ***RPh Initials:*** _____

-I have received verbal consent to report vaccine(s) to the registry for patients age 19 and older (NY only). ***RPh Initials:*** _____

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

Pharmacist Signature/Title: _____RPh_____ Date: _____

Pharmacy Intern Signature: _____ Date: _____

Location of Pharmacy/Administration: _____ Phone: _____

Additional Vaccine Administration Screening Questionnaire/Customer Information During COVID-19 Community Transmission

To help protect customers and associates during any period of declared COVID-19 community transmission, we are asking that all customers complete the following additional screening questions prior to being evaluated for vaccination need and administration.

We require customers to wear a face mask (*at minimum a disposable, ear loop surgical mask*) during the entirety of the vaccination process during any period of declared COVID-19 community transmission. If you do not have an appropriate face mask, one will be provided to you at no charge. If you have any condition that prevents you from wearing a mask, please alert the pharmacist and discuss deferring the vaccine administration until a time when there is no community transmission of COVID-19.

Please answer each of the following questions:			
1) Within the past 3 days, have you experienced fever or chills?	*(circle)*	**YES**	**NO**
2) Are you currently experiencing any of the following symptoms? Cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea.	*(circle)*	**YES**	**NO**
3) If you have recently experienced any of the above symptoms, have they improved over time? ☐ **YES, symptoms have improved** ☐ **NO, symptoms have stayed the same or have gotten worse** ☐ **N/A, have not experienced symptoms (skip to question 5)**			
4) How many days has it been since your symptoms first began? _____			
5) In the past 14 days, have you had close contact with any person with confirmed or suspected active COVID-19 infection?	*(circle)*	**YES**	**NO**