ShopRite Pharmacy Vaccine Consent Form & Screener

***REQUIRED INFORMATION ABOUT VACCINEE (PLEASE PRINT CLEARLY) – VACCINEE OR LEGAL GUARDIAN MUST SIGN WHERE INDICATED**

NAME (Last)*	**(First)***	**(M.I.)**	**DATE OF BIRTH*** _____/_____/_____ *MONTH DAY YEAR*
MAILING ADDRESS*			**GENDER*** ☐ MALE ☐ FEMALE
CITY*	**STATE***		**ZIP***
TELEPHONE*	**E-MAIL**	**DRUG ALLERGIES***	
VACCINEE'S PRIMARY PHYSICIAN	**PHYSICIAN'S ADDRESS & CONTACT INFO**		**DOCUMENTATION OF CONTACTING PATIENT'S PCP (WHERE APPLICABLE)**
ETHNICITY*: ☐ HISPANIC/LATINO ☐ NON-HISPANIC/LATINO ☐ UNKNOWN	**RACE*:** ☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ OTHER RACE ☐ UNKNOWN ☐ WHITE		

SCREENING QUESTIONS	YES	NO
Are you sick today or caring for someone who is ill? Do you have a fever greater than 100.4 °F (38.0 °C) within the past 72 hours and/or experiencing,nausea, diarrhea, or vomiting today?		
Are you allergic to eggs, Baker's yeast, preservatives, sulfites, thimerosal, streptomycin, neomycin,arginine, gelatin or latex?		
Have you ever had a serious reaction to any vaccine?		
Are you, anyone in your home, or anyone you take care of being treated with chemotherapy or radiation for Cancer, Leukemia, have HIV/AIDS or any immune deficiency disorder?		
Have you had Immune (Gamma) Globulin, a blood transfusion, blood products, plasma, or an antiviraldrug in the past year?		
Have you had Guillain-Barre Syndrome, a condition which causes paralysis?		
Are you taking any blood-thinning medications (i.e. aspirin, warfarin, etc.)?		
Have you had any recent immunizations? Which vaccine & when?		
Do you have any medical conditions such as: Heart Disease, Lung Disease, Asthma, Kidney Disease,Liver Disease, Metabolic Disease (e.g. Diabetes), Anemia, or other Blood Disease?		
Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment inthe past 90 days?		
For Women Only: Are you pregnant, planning to be pregnant or breastfeeding? *NOTICE: COVID-19 vaccination is recommended for people who are pregnant or breastfeeding. CDC recommendations align with those from professional medical organizations serving people who are pregnant, including the American College of Obstetricians and Gynecologists and the Society for Maternal Fetal Medicine. Reference: CDC COVID-19 Pregnancy Guidance Documents*		
Are you experiencing any of the following: Shortness of Breath, Cough, Chills, Muscle Pain, Headache, Sore Throat, Loss of Taste or Smell?		
In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or healthdepartment to isolate or quarantine at home due to COVID- 19 infection or exposure?		
***FOR CHILDREN COVID VACCINE**: Has there been any history of myocarditis or pericarditis? If so,when?		
***FOR CHILDREN COVID VACCINE**: Any history of Multisystem Inflammatory Syndrome (MIS-C)?If so, when?		

This assessment is intended to be used as (1) a screening tool prior to the administration of immunization services, and (2) a declaration of certain important information in addition to that disclosed in the consent form. This is not a diagnostic tool for determining COVID-19. All patients with confirmed or suspected cases of COVID-19 should follow CDC and physician guidance and refrain from immunizations until directed by a medical professional. Additional questions within this document are included to provide further screening for administration of the COVID-19 vaccine. PRECAUTIONS: The CDC recommends an observation period following vaccination with any vaccine. Persons with a history of an immediate allergic reaction of any severity to a vaccine/injectable therapy and/or persons with a history of anaphylaxis due to any cause should be observed for 30 minutes. All other persons should be observed for 15 minutes.

PHARMACY USE ONLY

ADMINISTERING IMMUNIZER: _____ **IMMUNIZER SIGNATURE:** _____

Vaccine Type & Product Name	Date of Dose & VIS Provision	Dose	Route/Site	Dose # (1st, 2nd, etc.)	Vaccine Manufacturer	Lot Number	Exp Date	VIS/EUA VERSION DATE
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			☐ IM ☐ SQ ☐ ID ☐ IN ☐ RIGHT ☐ LEFT ☐ ARM ☐ LEG					
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CONSENT STATEMENT FOR VACCINATION

I have read and understand the statements written on the back of this form. I GIVE CONSENT to ShopRite Pharmacy #_____and associated staff to administer this vaccine(s) to me or, if applicable, to this individual as their legal guardian. I understand that the information contained within this record is being maintained to monitor immunization needs in order to prevent disease. This information is confidential and will only be shared with organizations or persons who are authorized by law to receive it. ***(If the dosing consent statement of this form is not signed, dated, and returned, the person named above will not be vaccinated.) Your signature below authorizes this pharmacy to submit a record of this/these vaccination(s) to your respective state's vaccine registry where applicable.***

DOSING CONSENT:

PRINT VACCINEE or LEGAL GUARDIAN NAME: _____ ***DATE:*** _____

VACCINEE or LEGAL GUARDIAN SIGNATURE: _____ ***RELATIONSHIP:*** _____

MEDICARE BENEFICIARY STATEMENT

IF VACCINEE IS A MEDICARE-B BENEFICIARY*: Please submit my claim to Medicare. Medicare only pays for covered items and services when Medicare rules are met. I understand that Medicare will not decide whether to pay for the items and services described in this document until after these items and services have been provided to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. The purpose of this section is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.
Ask us to explain, if you don't understand why Medicare probably won't pay.Ask ushow much these items or services will cost you. With my signature in the CONSENT FOR VACCINATION section of Side 1 of thisdocument, I hereby declare that I understand the information in this section.

VACCINE CONSENT STATEMENT:
I have received and read the Vaccine Information Statement(s) ("VIS") for the vaccination(s) I wish to receive and have had the opportunity to ask questions. I have also had the opportunity to read and consider the ShopRite Privacy Practices Notice ("HIPAA") to my satisfaction prior to consent. I understand the benefits and risks of the vaccine(s). I accept that services might be rendered in a non-private setting. I agree to remain in the general area of the vaccination administration for at least 15-30 minutes after receiving the vaccination in the event that any immediate reactions occur. I understand that if I experience any side effects from this vaccination, I am responsible for following up with my physician at my own expense. I understand that wherever required, information pertaining to my receipt of this vaccine may be forwarded to my primary care physician or other health care provider, the authorizing physician, and the state or local health department or another health oversight agency. Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators and assignees, Wakefern Food Corp., its ShopRite member location, their employees, owners and representatives, as well as any company sponsoring this event and their agents, representatives, employees, successors, assignees, governing bodies, and advisory committees from any and all claims, demands, actions and causes of action, which may result from participation in this program. With my signature in the CONSENT FOR VACCINATION section of Side 2 of this document, I hereby consent to the administration of the vaccinations.

CONSENT TO PARTICIPATE STATEMENT FOR NJ IMMUNIZATION INFORMATION SYSTEM (NJIIS)

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me whenmy/my child's immunizations are due and to keep a central record of my/my child's immunization history.
I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A.26:4-131 et seq. and rules at
N.J.A.C. 8:57-3. There is no cost to participate in this program.
I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH Vaccine Preventable Disease Program may be contacted at website or telephone number listed below:
P.O. Box 369 / Trenton / NJ / 08625-0369 Ph: (609) 826-4860 Fax: (609) 826-4866
www.njiis.nj.gov

Pharmacist- Affix Label Here