ADULT VACCINATION SCREENING AND CONSENT FORM

Section 1: Patient Information

Name____ DOB:________________

Street Address____ Zip___________

Cell (____)___________________ Email__________________________________

☐ I give permission to Sewall's Point Pharmacy, Inc to **contact me via text and or email** for prescription notifications, health related information updates, and promotions/newsletters.

Gender: ☐ Male ☐ Female Notes:_________________________________

Drug/Food Allergies:____

Emergency Contact person:
Relation
Tel

VACCINES REQUESTED ☐ Covid-19 Primary Series ☐ Covid-19 Bivalent Booster

☐ Shingrix (Shingles) ☐ Twinrix (Hep A/B) ☐ Influenza Standard dose ☐ Influenza Adj/HD

☐ Tdap (Teatnus, Diptheria, pertussis) ☐ Pneumococcal

******PLEASE PROVIED YOUR MEDICARE ID OR COMMERCIAL INSURANCE CARD******

Section 2: Screening Questions

ALL VACCINATIONS		YES	NO	N/A
	1. Are you allergic to food/drugs, vaccines, vaccine components (neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol. Polymyxin, gelatin, yeast, polyethylene glycol, polysorbate)?			
	2. Have you had a reaction after getting vaccines such as fainting, dizziness, light-headed throat closure, severe hives, Guillain-Barre Syndrome.?			
	3. Are you currently sick of have you recently been treated with monoclonal antibodies?? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc. If so please elaborate:			
	4. Are you immunocompromised (HIV/Cancer) or are you on a chronic medicine that affects your immune system? **Advisory: people who are immunocompromised might be at increased risk for severe COVID-19 infections and have the potential for reduced immune responses.*			
	5. Do you have a bleeding disorder or take blood thinners?			
	6. Have you been diagnosed with Multisystem Inflammatory Syndrome in adults or children in the last 90 days?			
	7. Have you ever been diagnosed with Guillain-Barré syndrome?			
	8. Do you have a seizure, brain, or nerve problem?			

LIVE VACCINATIONS ONLY (MMR, VARICELLA, ROTAVIRUS, INTRANASAL INFLUENZA, POLIO)		YES	NO	N/A
	1. Are you immunocompromised (HIV/Cancer) or are you on a chronic medicine that affects your immune system such as high-dose steroids, or cancer treatment with radiation or drugs?			
	2. Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation?			
	3. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?			
	4. Are you immunocompromised (HIV/Cancer) or are you on a chronic medicine that affects your immune system?			
	5. . Have you received any vaccinations in the past 4 weeks?			
	6. Have you been diagnosed with Multisystem Inflammatory Syndrome in adults or children in the last 90 days?			
	7. Do you have a long-term health problem such as heart, lung, kidney, liver, or metabolic disease (e.g., diabetes), neurologic or neuromuscular disease, anemia or other blood disorder?			
	8. For women: Are you pregnant/is there a chance you could become pregnant during the next month?			

Section 3: FOR IMMUNOCOMPROMISED PATIENTS ONLY: I ATTEST to meeting at least one of the following Moderately or Severely immunocompromised criteria that qualify me for a three dose primary series plus all authorized booster doses of the MODERNA and PFIZER COVID-19 MRNA Vaccination: □ Acute treatment for solid tumor and hematologic malignancies, □ Receipt of solid-organ transplant and taking immunosuppressive therapy, □ Receipt of CAR-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy), □ Moderate or severe primary immunodeficiency (e.g. ,DiGeorge, Wiskott-Aldrich syndromes), □ Advanced or untreated HIV infection, □ Active treatment with high-dose corticosteroids (i.e.,≥20mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, TNF blockers, and other biologic agents that are immunosuppressive or immunomodulatory, □ Chronic conditions associated with varying degrees of immune deficit, such as asplenia, sickle cell and chronic renal disease, □ My doctor has instructed me that based on other diagnosed chronic conditions and current therapies I meet criteria equivalent to moderate - severe level of immunocompromise.

Signature ____ Date_________________

Print Name:____ Date of birth_________________

Section 4: Consent for Vaccination

I certify that I am: (a) the patient and at least 18 years of age or (b) the parent or legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of Sewall's Point Pharmacy, Inc, to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. I acknowledge that, depending upon my state's law, I may prevent the disclosure of my immunization information by the applicable Provider to the State Registry by using the opt-out form. The Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the Provider reporting my immunization information to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information as required or permitted by law. I voluntarily authorize and direct my healthcare provider at Sewall's Point Pharmacy, Inc to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at Sewall's Point Pharmacy, Inc my Primary Care Physician, my insurance and/or state or federal registries, where required, for the purpose of treatment, payment or other healthcare operations. I further agree to be fully financially responsible for any cost sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service.

FOR COVID-19 VACCINATIONS:

I have been given a copy and have read, or have had explained to me, the information in the FACT SHEET for the COVID-19 vaccine. I have had the chance to ask questions that were answered to my satisfaction. I understand the significant known and potential risks and benefits of the COVID-19 vaccine as explained in the FACT SHEET and that some potential risks and benefits may remain unknown, and I REQUEST THE COVID-19 VACCINE BE GIVEN TO ME. I agree to stay in the vaccine administration area for fifteen (15) minutes (or longer if indicated by the vaccine administrator) after receiving my vaccination to ensure that no immediate adverse reactions occur, and I understand that if I experience any adverse reaction, it will be my responsibility to follow up with my primary care physician. I understand the MODERNA and PFIZER COVID-19 vaccines requires 2 doses given 3-4 weeks apart to complete the vaccination series and I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the vaccination series.

Print Name ____ **Date** _____________________________

Signature ____ **Relation to Patient** □ **Self** □ **POA/Legal Guardian**

Section 4: Vaccination Record (pharmacy use only)

FOR ADMINISTRATIVE USE ONLY

Vaccines Administered	Dose Volume	Route	Date Administered	Vaccine Manufacturer / Lot/ Exp / VIS Date	Name of Vaccine Administrator
□ Influenza □ Shingrix □ Tdap □ Pneumococcal □ COVID-19 MRNA □ Hep A/HepB □ Other: ______________	□ 0.25 ml □ 0.5 ml □ 1 ml □ Other: ______ ml	IM - L DELTOID IM - R DELTOID IM-OTHER: ____________			□ ABBEY BUCKMAN □ JAE FORD □ CRISTAL TOTTERMAN

Administrator Signature ____ Date ___________________________