Vaccine Consent and Administration Record

PATIENT INFORMATION

Name:______________________________ **Date of Birth:**____/____/____

Gender:____________ **Phone:**_____________________

Home Address:_____________________________ **City, State:**______________________

Zip:_____________ **Email:**____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race:
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African-American
- ☐ White
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Other Race

Hy-Vee Pharmacy will send vaccination information from this visit to your primary care provider using the contact information provided below. **(Optional)**

Primary Care Provider (PCP) Name: ____

PCP Contact Information: ____

If someone else manages healthcare decisions on the patient's behalf, please provide the following:

Legal Decision-Maker Name:______________________

Relationship: ________________ **Phone:**_________________

INSURANCE INFORMATION - Please fill in all that apply

Prescription Insurance ☐ Check box if patient is the primary card holder

Primary Insurance Provider: ______________________________

Member ID #: _________________________ **RX Group #:** ____________________

RX BIN: ____________________ **RX PCN:** ____________________

Medicare Beneficiaries (the COVID Vaccine will be billed at Part B through your Medicare provider)

Is the patient age 65 or older or is the patient Medicare Eligible? ☐ Yes ☐ No

Medicare Number (MBI): ______________________

Medical Insurance ☐ Check box if patient is the primary card holder

Medical Insurance Provider: ______________________________

Member ID #: ________________________

Payer ID: ___________________

SCREENING QUESTIONS FOR VACCINATION(S)

The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Have you had any of the following symptoms in the past 14 days: Cough, muscle pain, fever or chills (temp > 100.4F), unexpected shortness of breath or difficulty breathing, sore throat, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, or diarrhea?	☐	☐	☐
3. Have you been in contact with anyone with confirmed or suspected Coronavirus (COVID-19) infection within the past 14 days?	☐	☐	☐
4. In the past 14 days, have you tested positive for COVID-19 or are you currently waiting on the results of a COVID-19 test?	☐	☐	☐

*****If you answered yes to any of the above questions (1-4), please speak with pharmacy staff before completing the rest of this form*****

5. Do you have allergies to medications, foods or any vaccine? (i.e. gelatin, eggs, latex, etc.) ☐ ☐ ☐

6. Have you ever had a serious reaction after receiving a vaccination? ☐ ☐ ☐

7. Do you have a chronic health condition such as heart disease, lung disease, kidney disease, obesity, metabolic disease (e.g., diabetes), blood disorder, or liver disease? ☐ ☐ ☐

8. For patients between the ages of 2 and 4 years: has a health care provider told you that the child had wheezing or asthma in the past 12 months? ☐ ☐ ☐

9. If the patient is a baby: have you ever been told he or she has had intussusceptions? ☐ ☐ ☐

10. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? ☐ ☐ ☐

11. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, home infusion, weekly injections (i.e. Humira, Enbrel, or Xeljanz), or have you had radiation treatments? ☐ ☐ ☐

12. Have you, a sibling, or parent had a seizure or a brain or other nervous system problem? (i.e. Guillain-Barre Syndrome, encephalopathy) ☐ ☐ ☐

13. Do you have a bleeding disorder or are you taking a blood thinner? ☐ ☐ ☐

14. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? ☐ ☐ ☐

15. For women: Are you pregnant or is there a chance you could become pregnant during the next month? ☐ ☐ ☐

16. Have you received any vaccinations or skin tests in the past 4 weeks? ☐ ☐ ☐

17. Are you currently on anticoagulant/antiplatelet medications? (Warfarin, aspirin, Plavix, Lovenox, etc.) ☐ ☐ ☐

18. Are you current on all your vaccinations? (Pneumonia, Shingles, TdaP, etc.) ☐ ☐ ☐

19. Please indicate the vaccine(s) you wish to receive today.
☐ Flu ☐ COVID-19 ☐ RSV (ages 60+) ☐ Shingrix (ages 50+)
☐ Prevnar 20

20. **For Shingrix vaccine recipients ONLY:**
Have you received a Shingrix vaccine dose in the past? ☐ ☐ ☐
If yes, list the date of the dose____________________

FOR COVID-19 VACCINE RECIPIENTS ONLY

21. **Patients ages 5 years and older:**
Have you ever received a dose of a COVID-19 vaccine? ☐ ☐ ☐
If yes, list the date of your last dose:________________

Patients under the age of 5:
Have you ever received a dose of a COVID-19 vaccine? ☐ ☐ ☐

If yes, which vaccine did you receive?
☐ Pediatric Pfizer (ages 3 or 4)
☐ Pediatric Moderna (ages 3-5)

Date of 1st dose: __________________ Date of 2nd dose:__________________
Date of 3rd dose (if applicable): _______________
Date of last/booster dose: ___________________

22. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? ☐ ☐ ☐

23. Are you eligible to receive an updated COVID-19 vaccine for the 2024-2025 season or an Additional Updated COVID-19 dose today, based upon current ACIP guidelines? ☐ ☐ ☐

If yes, which vaccine dose are you eligible to receieve today?

☐ Updated 2024-2025 Dose ☐ Additional Updated Dose

Which vaccine product are you eligible to receive today?

☐ Pediatric Pfizer (ages 3 or 4)
☐ Pediatric Moderna (ages 3-5)
☐ Pediatric Pfizer (ages 5-11)
☐ Pediatric Moderna (ages 6-11)
☐ Pfizer (ages 12+)
☐ Moderna (ages 12+)
☐ Novavax (ages 12+)

PATIENT CONSENT

CONSENT FOR VACCINE SERVICES. I have read, or have had read to me, the Vaccine Information Statement (VIS) or Emergency Use Authorization (EUA) Fact Sheet for Recipients and Caregivers provided for the vaccine(s) to be administered. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and voluntarily assume full responsibility for any reactions that may result. I give my consent to the staff of Hy-Vee Pharmacy to administer the vaccine(s) marked above. I have been advised to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. 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 Hy-Vee, its officers, employees and agents from any and all liability, whether known or unknown, that in any way arise from this vaccination on behalf of myself, my heirs and personal representatives.

PAYMENT AUTHORIZATION. I hereby authorize Hy-Vee Pharmacy to request payment and release all information needed to act on this request. I certify that the information given by me in applying for payment under Medicare or Medicaid is correct. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS. I acknowledge that Hy-Vee Pharmacy may be required to or may voluntarily disclose my health information concerning the vaccine(s) to my primary care physician (if provided), my insurance plan, and/or local, state, or federal registries/health agencies, if applicable. I acknowledge that, depending on my state law, I may object to the disclosure of my vaccination information to the state registry. I understand that my health information will be used and disclosed as set forth in the Hy-Vee Pharmacy Notice of Privacy Practices, which is available online or upon request.

By signing below, I certify that I am the patient or the patient's guardian/representative authorized to provide consent on their behalf, and that I have read, understand and agree to all the statements on this form.

______________________________ ________________

Patient or Guardian Signature Date

PHARMACY USE ONLY

Vaccine	Admin Date	Dose (mL)	Vaccine			Route (IM/SQ/NAS)	Site (RA/LA, RT/LT)	VIS or EUA Fact Sheet:	
			Lot #	Exp Date	Manufacturer			Pub Date	Date Given

Administering Immunizer Name & Title: ____

Administering Immunizer Signature: ____

Pharmacy Address: ____________________________

City, State, Zip: ___________________________ **Store #:** ______________

If applicable,
Supervising Pharmacist Name: ______________________________

Supervising Pharmacist Signature: ___________________________

Adverse Reaction (attach VAERS form) Notification to Primary Provider:

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Date:_____________________