

Giant/Martins Pharmacy Vaccine Informed Consent rev 5.2023

| | | | | | | | | | |
|--|-------|----------------------|--|---|---------------|------------|-----------|--------------------------|--------------------------|
| Store: | Type: | Date: | Conf. #: | | | | | | |
| Name: _____ | | Date of Birth: _____ | | Age: _____ | Gender: _____ | | | | |
| Address: _____ | | City: _____ | County: _____ | State: _____ | Zip: _____ | | | | |
| Email Address: _____ | | Home Phone: _____ | Mobile Phone: _____ | | | | | | |
| Primary Care Provider: _____ | | | Provider Phone Number: _____ | | | | | | |
| Provider Address: _____ | | | I do not currently have a Primary Care Provider <input type="checkbox"/> | | | | | | |
| I would like a copy of this consent form <input type="checkbox"/> | | | | | | | | | |
| Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native | | | | Ethnicity: <input type="checkbox"/> Unknown <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino | | | | | |
| Screening Questionnaire. Ask or contact the pharmacist for any assistance. | | | | | | Yes | No | | |
| What vaccine or vaccines are you interested in receiving today? Check all that apply. <i>A pharmacist will review your answers to determine what vaccines you are eligible to receive today. *If interested in COVID vaccine please make that your primary appointment, as products and locations may vary*</i> <input type="checkbox"/> COVID-19 <input type="checkbox"/> Flu <input type="checkbox"/> Shingles <input type="checkbox"/> Tetanus/Tdap <input type="checkbox"/> Pneumonia <input type="checkbox"/> Other(s): _____ | | | | | | | | | |
| Do you feel sick today (For example: a cold, fever, or acute illness?) _____ | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever received a Bivalent COVID-19 vaccine? When was your last dose: _____ | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you bring your vaccination record card or other documentation? _____ | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? _____ | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a history of allergic reaction or allergies to vaccines, <i>vaccine components</i> , medications (including injectable therapies), latex, or foods? <i>Examples: COVID-19 vaccine, polyethylene glycol (PEG), polysorbate, eggs, yeast, preservatives, phenol, thimerosal, streptomycin, neomycin, gelatin, latex, bovine protein.</i> *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. | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a severe reaction to any vaccine which required medical care including fainting or feeling dizzy? _____ | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you received a vaccine in the past 4 weeks? _____ | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A), myocarditis or pericarditis? _____ | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you receiving a hematopoietic cell transplant (HCT) or CAR-T cell therapies? _____ | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a chronic health condition such as heart disease, chronic lung disease, chronic kidney disease, diabetes, asthma, blood disorder, complement component deficiency, no spleen, a cochlear implant, or spinal fluid leak? _____ | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a seizure, brain, or any other neurological disorder, or have you had Guillain-Barré Syndrome, a condition which causes paralysis? _____ | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? <i>This includes being treated with prednisone, other steroids, weekly injections, anticancer drugs, or radiation.</i> | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you taken any antivirals (i.e. Tamiflu, valacyclovir) within the past 48 hours? _____ | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a bleeding disorder, take a blood thinner, take aspirin or any aspirin-containing products, or have a history of Heparin Induced Thrombocytopenia (HIT) or thrombosis with thrombocytopenia syndrome (TTS)? _____ | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| For Travel Vaccines only: Please indicate all countries you will visit on your trip (including stopovers): _____ | | | | | | | | | |
| For Yellow Fever Vaccine only: Do you have thymus gland disease, or have you had your thymus gland removed? _____ | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you pregnant, planning to become pregnant, or breastfeeding? _____ | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| For emergency use only, please indicate the patient's weight category: <33lbs <input type="checkbox"/> 33-66lbs <input type="checkbox"/> >66lbs <input type="checkbox"/> | | | | | | | | | |
| Check any condition below that applies to you so we may screen for other needed vaccinations: Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Smoker <input type="checkbox"/> Heart Condition <input type="checkbox"/> Lung Condition <input type="checkbox"/> 50 or older <input type="checkbox"/> | | | | | | | | | |
| Have you had the following vaccines? Influenza <input type="checkbox"/> Pneumonia <input type="checkbox"/> Meningitis <input type="checkbox"/> Shingles <input type="checkbox"/> Tetanus/Whooping Cough <input type="checkbox"/> Hepatitis <input type="checkbox"/> | | | | | | | | | |
| Medicare B #: | | Last 4 SSN: | | Pharmacy Insurance Information RX ID #: | | | | | |
| Name as it Appears on Card: | | | | RX BIN: | RX PCN: | RX Group: | | | |

| PHARMACIST USE ONLY | | | | | | | | |
|--------------------------------|------------|--------|-----|----------|-----|--------------|--|----------------------|
| Admin Date/EUA or VIS Given on | Vaccine/mL | Dose # | Lot | EXP Date | BUD | Manufacturer | Injection Site: PLUA - Post Lateral Upper Arm - SQ Deltoid - IM | EUA/VIS Revised Date |
| | | | | | | | IM/SQ L/R Deltoid/PLUA | |
| | | | | | | | IM/SQ L/R Deltoid/PLUA | |
| | | | | | | | IM/SQ L/R Deltoid/PLUA | |

Pharmacist/Intern/Technician Name: _____ Title: _____ Date: _____

PHARMACIST USE ONLY CONTINUED

Registry checked to confirm appropriate dose(s) number/product: YES NO Date: _____

Pharmacist Notes:

I have reviewed the Vaccine Screening Questionnaire to assess the patient for potential contraindications and precautions to the vaccines being administered today. I have confirmed vaccine requested is indicated for the patient. RPh Initials: _____

Copy sent to provider: YES NO

Certificate of Immunization given to patient: YES NO

Next Dose Date: _____ Next Dose Time: _____

Pharmacist/Intern/Technician Signature: _____ NPI: _____

Location of Pharmacy/Administration: _____ Phone: _____

Emergency Use Authorization: The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same time of review as an FDA-approved or cleared product. However, the FDA’s decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

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 Giant/Martins pharmacist. Where applicable and accepted by state regulations, I consent to my vaccine being administered by a Giant/Martins pharmacy intern or technician. I acknowledge I have the right to ask for a copy of the Giant/Martins 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. For COVID-19 Vaccine: I have been provided and have read, or had explained to me, the patient fact sheet corresponding to the COVID-19 vaccination given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). 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 request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). 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 and may need to remain for 30 minutes (if required based on answers to screening questions above) 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 Giant/Martins 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 Giant/Martins 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 Giant/Martins 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.

Informed Consent

| | |
|--|-------------------------|
| Patient Name (printed): _____ | Date of Birth: _____ |
| Patient or Patient’s Personal Representative Signature*: _____ | Date: _____ |
| <i>*A Personal Representative is someone who has legal authority to make healthcare decisions on the behalf of the patient</i> | |
| Patient Guardian Name (printed): _____ | Guardian Type: _____ |