Giant Food Pharmacy Vaccine Informed Consent Form

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

Phone Number: _____

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

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

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

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)		
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 ever had a severe reaction to any vaccine which required medical care?		
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?		
If 50 or older have you received a shingles vaccination since January of 2018?		
There are 2 pneumonia vaccines– If 65 or older have you received a pneumonia vaccination after September of 2014?		

Check any condition below that applies to you so we may screen for other needed vaccinations:

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

Have you received the following vaccinations?

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

I certify that I am: (i) the Patient and at least 18 years of age; (ii) the patient personal representative. I consent to, or give consent for, the administration of the vaccine(s) marked below by a Giant Food pharmacist. Where applicable and accepted by state regulations, I consent to my vaccine being administered by a Giant Food pharmacy intern. I acknowledge I have the right to ask for a copy of the Giant Food Pharmacy 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, 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 Giant Food 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.

X_____ *I would like a copy of this completed consent* ☐ **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 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:*** _____

-Certificate of Immunization given to patient: YES☐ NO☐

-Copy sent to provider: YES☐ NO ☐

Pharmacist Signature/Title: _____RPh__ Date: _____

Pharmacy Intern Signature: _____ Date: _____

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 the following questions	**Yes**	**No**
1) Within the past 3 days, have you experienced fever or chills?		
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		
3) If you have recently experienced any of the above symptoms, have they gotten worse/remained the same, and has it been less than 10 days since they first appeared?		
4) In the past 14 days, have you had close contact with any person with confirmed or suspected active COVID-19 infection?		