StarMeds Pharmacy Vaccine Consent Form & Screener

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

NAME (Last)*	**(First)***	**AGE**	**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 PHONE**	**ETHNICITY /RACE*: *:**	
PHYSICIAN'S ADDRESS	○ **I want my vacine Documentation to be sent to my Primary care/other physcian** ◉ **I DO NOT want my vacine Documentation to be sent to my Primary care/other physcian**		
I want to receive the following vaccination(s):			

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?	○	○
Do you have a history of allergic reaction or allergies to latex, medications, food or vaccines (examples: polyethylene glycol,polysorbate, preservatives, sulfites, arginine, eggs, bovine protein, gelatin, gentamicin,streptomycin, polymyxin, neomycin, phenol, yeast or thimerosal)?	○	○
Have you ever had a serious reaction to any vaccine?	○	○
Have you ever fainted or felt dizzy after receiving an immunization?	○	○
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?	○	○
Do you have any medical conditions such as:Heart Disease, Lung Disease, Asthma, Kidney Disease,Liver Disease, Diabetes, Anemia, obesity, sickle cell diseaseor other Blood Disease?	○	○
Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome(a condition that causes paralysis) or other nervous system problem?	○	○
Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner (i.e. aspirin, warfarin, etc.)?	○	○
Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment inthe past 90 days?	○	○
Have you had any recent immunizations? Which vaccine & when?	○	○
Have you had Immune (Gamma) Globulin, a blood transfusion, blood products, plasma, or an anti viral drug in the past year?	○	○
Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, or anti-cancer drugs, or have you had any radiation treatments?	○	○
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?	○	○
Has there been any history of myocarditis or pericarditis? If so,when?	○	○
For Women Only: Are you pregnant, planning to be pregnant or breastfeeding?	○	○
FOR CHILDREN COVID VACCINE: Any history of Multisystem Inflammatory Syndrome (MIS-C)?If so, when?	○	○
For MMR: Do you have a history of thrombocytopenia or thrombocytopenic purpura?	○	○

Have you ever received the following vaccinations?

Pneumonia: Date received Shingles: Date received Whooping cough: Date received

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
			☐ IM ☐ SQ ☐ ID ☐ IN ☐ R. ARM ☐ L. ARM					
			☐ IM ☐ SQ ☐ ID ☐ IN ☐ R. ARM ☐ L. ARM					
			☐ IM ☐ SQ ☐ ID ☐ IN ☐ R. ARM ☐ L. ARM					

CONSENT STATEMENT FOR VACCINATION

MEDICARE BENEFICIARY STATEMENT

IF VACCINEE IS A MEDICARE-B BENEFICIARY*: Please submit myclaim 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, I hereby declare that I understand the information in this section.

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

VACCINE CONSENT STATEMENT:

I certify that I am:(a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. I hereby give my consent to StarMeds Pharmacy and the certified-immunizing pharmacist, pharmacy intern (if permitted), Pharmacy tech (if permitted) or the licensed healthcare professional to administer the vaccine(s) I have requested.

I understand that it is not possible to predict all potential side effects or complications associated with receiving vaccine(s). I have received and read the Vaccine Information Statement(s) ("VIS") developed by the Centers for Disease Control and Prevention (CDC) for the vaccine(s) I wish to receive. I have had the opportunity to ask questions, and those questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s), including potential side effects and adverse reactions. I acknowledge that the administration of an immunization or vaccine does not substitute for an annual check-up with my primary care provider. I have received a copy of StarMeds Pharmacy's Notice of Privacy Practices and this Consent Form.

I understand that services may be rendered in a non-private setting and that I am advised to remain in the general area of vaccine administration for at least 15–30 minutes following vaccination in case of any immediate reactions. If I experience any side effects, I understand it is my responsibility to follow up with my physician at my own expense.

I understand the purposes/benefits of my state's vaccination registry ("State Registry"). I understand that my immunization information may be disclosed to my state's immunization registry ("State Registry") and health information exchange ("State HIE") for public health reporting and care coordination. I understand that I may opt out of such disclosures by submitting a state-approved opt-out form. Unless I provide such a form, my consent will remain in effect until withdrawn. I acknowledge that my vaccination documentation may be forwarded to: my primary care physician or other healthcare provider (if identified), the collaborative prescribing physician for this program, any state or federal governmental agencies or authorities (e.g., CDC, HHS) as required by law.

I authorize StarMeds Pharmacy to: a) Release my medical or other health information, including communicable disease (including HIV), mental health, and substance use information, to or through the State HIE to my healthcare providers, Medicare, Medicaid, or other third-party payers as necessary for care or payment. b) Submit claims to my insurer for the requested services and request payment of authorized benefits on my behalf. c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. 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 or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice.

On behalf of the patient , patient's heirs, executors, administrators, and personal representatives, I hereby release, hold harmless and forever discharge StarMeds Pharmacy, its affiliated member locations, Pharmacist, contracted pharmacist, Pharmacy interns, pharmacy techs, each applicable Provider, employees, owners, representatives, staff, agents, directors, contractors, successors, and assignees, as well as any company sponsoring this event and their agents, governing bodies, and advisory committees, from any and all liability, claims, demands, actions, or causes of action whether known or unknown that may arise or result , in connection with, or in any way related from the administration of the vaccine(s) or from participation in this program. I further release the collaborative prescribing physician, their affiliated entities, officers, employees, agents, and representatives from any and all liability that might result from the administration of the vaccine(s).

I have read and understand the statements written. I GIVE CONSENT to StarMeds 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:*** _____

Pharmacist- Affix Label Here