Northside Pharmacies

AN AFFILIATE OF GENESIS HEALTHCARE SYSTEM

2022-2023 VACCINE ADMINISTRATION CONSENT FORM

Northside Pharmacy Locations
❒ Taylor St ❒ MVHC
❒ Cambridge ❒ New Concord
❒ Forest Ave ❒ Pavilion
❒ Maysville ❒ Roseville
❒ Somerset

SECTION A: PATIENT INFORMATION

First Name	MI	Last Name	Today's Date	
Address			Ethnicity	Race
City	State	Zip	Phone #	
Family Doctor	Weight (For Needle/Epipen Determination)	Age	Birthdate	

SECTION B: VACCINE

I would like to receive the following vaccine(s):

❒ Flu

❒ Meningitis

❒ MMR (Measles, Mumps, & Rubella)

❒ Tdap (Tetanus, Diphtheria, & Pertussis-whooping cough)

❒ Td (Tetanus & Diphtheria)

❒ Pneumonia: Pneumovax 23 ❒ Prevnar 20 ❒

For Pneumonia Vaccine only: Have you ever received a pneumonia vaccine?.....❒ Yes ❒ No
If yes, please list **which** pneumonia vaccine and **when:**
_____

❒ Shingrix (Shingles): Dose 1 ❒ Dose 2 ❒

For Shingles Vaccine only: Have you ever had chicken pox, shingles, or have you ever received the chicken pox vaccine (2 doses).....❒ Yes ❒ No

I would like to receive the following COVID-19 vaccine:

❒ Pfizer

❒ Johnson & Johnson/Janssen

Dose 1 ❒ Dose 2 ❒ Additional Dose ❒

Name of COVID-19 vaccine previously received (if applicable):

❒ Moderna

❒ Pfizer

❒ Johnson & Johnson/Janssen

Please document date(s) of previous COVID-19 vaccine administration (if applicable):

❒ 1st Dose: _____ (mm/dd/yyyy)

❒ 2nd Dose:_____ (mm/dd/yyyy)

❒ 3rd Dose:_____ (mm/dd/yyyy)

SECTION C: SCREENING QUESTIONS

1. Are you sick today?.....❒ Yes ❒ No

2. Have you ever had a serious reaction after receiving a vaccination or an injectable medication?.....❒ Yes ❒ No
   If yes, please list vaccine/medication and reaction:
   _____

3. Do you have an allergy to any foods, medications, animals, or vaccine ingredients (e.g. eggs, latex, gentamicin, polymyxin, neomycin, Neosporin, kanamycin, barium, thimerosal, phenol, yeast, gelatin, formaldehyde, polyethylene glycol, polysorbate, etc.)?
   .....❒ Yes ❒ No
   If yes, please list allergy:_____

4. Have you ever had Guillain Barré Syndrome (a type of temporary severe muscle weakness), seizures, brain disorder, or neurological problems?.....❒ Yes ❒ No

5. Have you received any vaccine within the last 28 days?.....❒ Yes ❒ No
   If yes, please list vaccine and date: _____

6. Do you have a condition that may weaken your immune system (e.g. cancer, transplant, HIV/AIDS, tuberculosis, etc.)?.....❒ Yes ❒ No

7. In the past 3 months, have you taken any medications that may affect your immune system (e.g. chemotherapy, radiation treatments, steroids, methotrexate, azathioprine, 6-mercaptopurine, any other treatments for autoimmune diseases, or antivirals, etc.)?.....❒ Yes ❒ No
   If yes, please list medication and dosage_____

8. In the past year, have you received a blood transfusion, blood products, or been given a medication called immune (gamma) globulin?.....❒ Yes ❒ No

9. Do you have a history of thrombocytopenia (a condition that causes you to have an abnormally low number of platelets in your blood)?.....❒ Yes ❒ No

10. Which arm(s) would you prefer the vaccine(s)?
    Left Arm ❒ Right Arm ❒

11. For Women: Are you pregnant, breastfeeding, or considering becoming pregnant within the next 3 months?.....❒ Yes ❒ No

SECTION D: COVID-19 VACCINE ONLY

For COVID-19 Vaccines ONLY. Please complete additional screening questions below:

- ❒ History of heparin-induced thrombocytopenia
- ❒ History of thrombosis with thrombocytopenia syndrome (TTS)
- ❒ Have a history of myocarditis or pericarditis
- ❒ Have a history of Multisystem Inflammatory Syndrome (MIS-C Or MIS-A)
- ❒ Have a history of COVID-19 disease within the past 3 months
- ❒ Receiving active cancer treatment for tumors or cancers of the blood
- ❒ Received organ transplant and taking medicine to suppress immune system
- ❒ Received stem cell transplant within last 2 years and taking medicine to suppress immune system
- ❒ Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
- ❒ Advanced or untreated HIV infection
- ❒ Active treatment with medication(s) that suppresses immune system
  Please specify:_____

For COVID-19 Vaccine Booster Doses ONLY. Please attest to one of the criteria below for COVID-19 booster dose eligibility:

❒ I am **12** years of age or older AND have completed my primary vaccination with any authorized or approved COVID19 vaccine **at least 2 months ago**

❒ I am **12** years of age or older AND have completed my most recent booster dose with any authorized or approved COVID19 vaccine **at least 2 months ago**

COVID-19 Vaccination Attestation. Please attest to the following:

- ❒ I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet or Vaccine Information Statement (VIS-if available), a copy of which I was provided with this Consent Form. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent Form.
- ❒ I understand that some COVID-19 vaccines require multiple doses given weeks apart depending on the manufacturer. I will bring my vaccine card with me for subsequent doses to be completed.
- ❒ If insured, please present your prescription AND medical insurance cards to a pharmacy staff member. I authorize the pharmacy to bill my insurance on my behalf for the immunization administration fee only– understanding I will not incur any costs.
- ❒ If uninsured, please complete the information below:
  - ❒ I do **not** have any insurance, including but not limited to, Medicare, Medicaid, or any other private or government-funded benefit plan.

    Social Security Number: _____-_____-_____

SECTION E: CONSENT

I hereby give my consent to the eligible healthcare provider at Northside Pharmacy, to administer the vaccine(s) that I have requested. I have read or had explained to me the CDC's most current Vaccine Information Statement for the elected vaccine(s), and understand the risks and benefits associated. I understand that with all vaccinations there is a possibility of a complication or adverse reaction. I hereby fully hold harmless and release Northside Pharmacy, its affiliates, director, and all employees from any and all liabilities which may arise from the administration of the requested vaccine. In addition, I acknowledge that I have had the opportunity to ask questions and that my questions were answered to my satisfaction. I understand that my information will remain confidential, but will be shared with state immunization registries or the State Health Division. I understand that the state registry may share this information with other healthcare providers. I understand that this information will not be released except as permitted or required by law. I authorize Northside to submit a claim with respect to the above services, to Medicare, Medicaid, or any other contracted third party. I agree to be financially responsible for any copays, deductibles, or denied claims.

Following vaccine administration, I acknowledge that I need to remain near the vaccination location for approximately 15-20 minutes for observation.

→Patient Signature:_____Date:_____

(Parent/Legal Guardian Signature if patient is under age 18)

SECTION F: FOR PHARMACY USE ONLY

Vaccine	Vaccine Name	Lot Number	Manufacturer	Expiration Date	Dosage (mL)	Route/Injection Site	Date of VIS or EUA
						IM L / R Deltoid SQ L / R Arm	
						IM L / R Deltoid SQ L / R Arm	
						IM L / R Deltoid SQ L / R Arm	

****If sterile diluent/adjuvant is used, please list Lot Number/Manufacturer/Expiration Date_____**

****Signature & Title of Vaccine Administrator: _____Date: _____**