ShopRite Vaccine Administration Consent Form

INFORMATION ABOUT VACCINEE (PLEASE PRINT CLEARLY) – VACCINEE OR LEGAL GUARDIAN MUST SIGN BELOW

NAME (Last)*	(First)*	(M.I.)	DATE OF BIRTH* _____ / _____ / _____ month / day / year
MAILING ADDRESS*			GENDER* ☐ MALE ☐ FEMALE
CITY*	STATE*		ZIP*
TELEPHONE*	e-Mail		
VACCINEE'S PRIMARY PHYSICIAN	PHYSICIAN'S ADDRESS & CONTACT INFO		
INSURANCE INFORMATION	MISCELLANEOUS/Documentation of contacting patient's PCP (Maryland Only)		

*Required Information

SCREENING FOR INJECTABLE VACCINE ELIGIBILITY*

SCREENING QUESTIONS	YES	NO
Are you sick today? Do you have a fever, diarrhea, or vomiting today?		
Are you allergic to eggs, Baker's yeast, preservatives, sulfites, thimerosal, streptomycin, neomycin, arginine, gelatin or latex?		
Have you ever had a serious reaction to any vaccine?		
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?		
Have you had Immune (Gamma) Globulin, a blood transfusion, blood products, plasma, or an antiviral drug in the past year?		
Have you had Guillain-Barre Syndrome, a condition which causes paralysis?		
Are you taking any blood-thinning medications (i.e. aspirin, warfarin, etc.)?		
Have you received any immunizations in the last 30 days?		
Do you have any medical conditions such as: Heart Disease, Lung Disease, Asthma, Kidney Disease, Liver Disease, Metabolic Disease (e.g. Diabetes), Anemia, or other Blood Disease?		
For Tdap Only: Do you have progressive or unstable neurologic disease, uncontrolled seizures, or progressive encephalopathy?		
For Women Only: Are you pregnant or planning pregnancy in the next month?		

*** NOTE: At the sole discretion of the Pharmacist, a "YES" answer to any of these questions may warrant referral to a Physician for further evaluation to determine the eligibility of the person to receive a vaccination.**

PHARMACY USE ONLY
ADMINISTERING RPh: _____ RPh SIGNATURE: _____

Vaccine	Date of Dose & VIS Provision	Dose	Route/Site	Dose # (1st, 2nd, etc.)	Vaccine Manufacturer	Lot Number	Exp Date
Seasonal Influenza			☐IM ☐ID ☐R ☐L ☐Arm ☐Leg				
PPSV			IM ☐R ☐L ☐Arm ☐Leg				
Zoster Vaccine			SQ ☐R ☐L ☐Arm ☐Leg				
Tdap			IM (Deltoid) ☐R ☐L				
VIS Version	INFLUENZA: _____ PPSV: _____ ZOSTER: _____ Tdap:_____ Other: _____						

CONSENT STATEMENTS FOR VACCINATION

I have read and understand the statements written on the back of this form. I GIVE CONSENT to ShopRite Pharmacy #_____ and associated staff to administer this vaccine(s) to me or, if applicable, to this individual as his/her 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.)***

DOSING CONSENT:

PRINT VACCINEE/LEGAL GUARDIAN NAME: _____ ***DATE:*** _____

VACCINEE/LEGAL GUARDIAN SIGNATURE: _____ ***RELATIONSHIP:***_____

VACCINE REGISTRY CONSENT: YOUR SIGNATURE BELOW AUTHORIZES THIS PHARMACY TO SUBMIT A RECORD OF THIS/THESE VACCINATION(S) TO YOUR RESPECTIVE STATE'S VACCINE REGISTRY WHERE APPLICABLE.

VACCINEE/LEGAL GUARDIAN SIGNATURE: _____

WHITE COPY = Pharmacy Record - Keep in Rx Dept YELLOW COPY = Give to Patient or Guardian PINK COPY = Physician or Other HCP if necessary

Wakefern GW – Pharmacy Division Form # 11-7910010

VACCINE CONSENT STATEMENT

I have received and read the Vaccine Information Statement(s) ("VIS") for the vaccination(s) I wish to receive and have had the opportunity to ask questions. I have also had the opportunity to read and consider the ShopRite Privacy Practices Notice ("HIPAA") to my satisfaction prior to consent. I understand the benefits and risks of the vaccine(s). I accept that services might be rendered in a non-private setting. I agree to remain in the general area of the vaccination administration for at least 10-15 minutes after receiving the vaccination in the event that any immediate reactions occur. I understand that if I experience any side effects from this vaccination, I am responsible for following up with my physician at my own expense. I understand that wherever required, information pertaining to my receipt of this vaccine may be forwarded to my primary care physician or other health care provider, the authorizing physician, and the state or local health department or another health oversight agency. Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators and assignees, Wakefern Food Corp., its ShopRite member location, their employees, owners and representatives, as well as any company sponsoring this event and their agents, representatives, employees, successors, assignees, governing bodies, and advisory committees from any and all claims, demands, actions and causes of action, which may result from participation in this program. With my signature in the CONSENT FOR VACCINATION section of Side 1 of this document, I hereby consent to the administration of the vaccinations.

MEDICARE BENEFICIARY STATEMENT

IF VACCINEE IS A MEDICARE-B BENEFICIARY*: Please submit my claim 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 us how much these items or services will cost you.

With my signature in the CONSENT FOR VACCINATION section of Side 1 of this document, 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 when my/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

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Pharmacist – Affix Vial Rx Label Here

***PHARMACISTS: THIS IS NOT A SUBSTITUTE FOR AOB/ABN REQUIREMENTS**