VACCINE(S) YOU ARE HERE FOR TODAY: ___________________________ **JGS PHARMACIES, INC.**

DOLLAR DRUG

CONSENT AND RELEASE – VACCINATIONS

LAST NAME	FIRST NAME	MIDDLE NAME
DATE OF BIRTH	GENDER ☐ **M** ☐ **F**	PHONE # INCL AREA CODE

ADDRESS	CITY	STATE	ZIP

PRIMARY INSURANCE	INSURANCE ID	MEDICARE # (NUMBERS & LETTERS)

NAME OF PRIMARY CARE PHYSICIAN	ADDRESS INCLUDE CITY AND STATE	PHONE # INCL AREA CODE

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. Further, I hereby give my consent to Dollar Drug and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the EUA Fact Sheet on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Centers for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the applicable Provider: (a) the disclosure of my vaccination information by the applicable Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and, to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies, State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws or federal law may permit certain disclosures of my vaccination information to or through the State HIE or to Government Agencies as required or permitted by law. I further authorize the applicable Provider to: (a) release my medical or other information, including any communicable disease (including HIV) and mental health information, to, or through, the State HIE or Government Agencies to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (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. Dollar Drug or its affiliates may contact you, including by autodialed and prerecorded calls and texts, at any time, using the contact information provided in your patient record regarding health and safety matters, such as vaccine reminders.

____ ______________________

SIGNATURE OF PERSON TO RECEIVE VACCINE (S) **DATE**

____

PRINT NAME

	Please answer these questions by checking the boxes. If a question is not clear, please ask the Pharmacist to explain it. **If you are receiving the Covid-19 vaccine, please answer questions, on back of this page.**	Yes	No	Don't Know
1.	**Are you sick today?**			
2.	Do you have a **serious allergy** to medication or food? For example: Eggs, Thimerosal, Neomycin, or Gentamicin?			
3.	Have you ever had **a serious reaction or fainted** after receiving a vaccine?			
4.	Do you have cancer, leukemia, HIV, or any other immune system problem?			
5.	Do you take cortisone, prednisone, other steroids, anticancer drugs or anti-viral medications?			
6.	Do you have sensitivity to latex? (Gloves, Bandages)			
7.	During the past year, have you received radiation therapy, had a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin? (For live vaccines)			
8.	Have you received any vaccinations in the past 4 weeks? (For live vaccines)			
9.	**For Women:** Are you pregnant or are you considering becoming pregnant?			
10.	**Which shoulder would you like your vaccination in today? Please circle.**	**LEFT**	**OR**	**RIGHT**

FOR PHARMACY USE ONLY:

Vaccine	Lot#	Exp. Date	Manufacturer	Dosages	Site of Injection	Time	VIS Date
Influenza				0.5ML	IM L / R Deltoid		8/6/2021
Shingrix				Standard	IM L / R Deltoid		2/4/2022
Prevnar 20				Standard	IM L / R Deltoid		5/12/2023
Arexvy				0.5ML	IM L / R Deltoid		7/24/2023
Spikevax				0.5ML	IM L / R Deltoid		9/2023

Prevaccination Checklist for COVID-19 Vaccination

Name ______________________

For vaccine recipients (both children and adults):

The following questions will help us determine if there is any reason COVID-19 vaccine cannot be given today. **If you answer "yes" to any question, it does not necessarily mean the vaccine cannot be given.** It just means additional questions may be asked. If a question is not clear, please ask the healthcare provider to explain it.

Question	Yes	No	Don't know
1. How old is the person to be vaccinated? ______			
2. Is the person to be vaccinated sick today?	☐	☐	☐
3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product was administered? ☐ Pfizer-BioNTech ☐ Janssen *(Johnson & Johnson)* ☐ Another Product ☐ Moderna ☐ Novavax ______			
• How many doses of COVID-19 vaccine were administered? ______			
• Did you bring the vaccination record card or other documentation?	☐	☐	
4. Does the person to be vaccinated have a health condition or is undergoing treatment that makes them moderately or severely immunocompromised? *This would include, but not be limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.*	☐	☐	☐
5. Has the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
6. Has the person to be vaccinated ever had an allergic reaction to: *(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 caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. Has the person to be vaccinated ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? *(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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

8. Check all that apply to the person to be vaccinated:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a history of Guillain-Barré Syndrome (GBS)
- ☐ Have a history of COVID-19 disease within the past 3 months?
- ☐ Vaccinated with monkeypox vaccine in the last 4 weeks?

Form reviewed by ______________________ **Date** ______________