Discount Drug Mart Vaccine Administration and Consent Form

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)				
FIRST NAME:	**LAST NAME:**			**HOME ADDRESS COUNTY:**
ADDRESS:	**CITY:**		**STATE:**	**ZIP CODE:**
DATE OF BIRTH:	**AGE:**	**GENDER:**	**PHONE NUMBER:**	
ALLERGIES:		**CHRONIC ILLNESS:**		
PRIMARY CARE PHYSICIAN:	**ADDRESS:**		**PHONE NUMBER:**	
PARENT/GUARDIAN FIRST NAME:	**PARENT/GUARDIAN LAST NAME:**		**PARENT/GUARDIAN PHONE NUMBER:**	

RACE (CIRCLE ONE):	**ETHNICITY:**
White **Black/African American** **Hispanic**	**Are you of Hispanic, Latino, or Spanish origin? (SELECT ONE):**
Asian **American Indian/Alaskan Native** **Prefer Not to Answer**	□ **Yes-Please specify:**_____
Native Hawaiian/Other Pacific Islander **Other**	□ **No-Not Hispanic, Latino, or Spanish origin**

VACCINES TO BE ADMINISTERED (circle all that apply):

COVID Influenza (Flu) Hepatitis A Hepatitis B Hepatitis A & B Hib
HPV Meningitis B Meningitis ACWY MMR MMR/Varicella Pneumonia
Polio Td Tdap Varicella (Chicken Pox) Zoster (Shingles)

SCREENING QUESTIONNAIRE FOR IMMUNIZATIONS	**YES**	**NO**
1. Are you sick today?		
2. Do you have any allergies to medication, food, latex, yeast, neomycin, gelatin, or any vaccine component? Please list:		
3. Have you ever had a serious reaction after receiving a vaccine?		
4. Have you ever received a COVID, Hepatitis, MMR, Meningitis, Pneumonia, or Zoster (Shingles) vaccine? If Yes, which vaccine?		
5. Have you had any vaccines administered to you in the past 2 OR 4 weeks?		
6. Do you have asplenia or abnormal spleen function?		
7. Do you have a history of Guillain-Barre syndrome (GBS)?		
8. Do you have a history of thrombocytopenia or thrombocytopenic purpura?		
9. Are you currently taking any anti-viral medication or blood thinners?		
10. Do you, anyone who lives with you, or anyone you take care of: Take cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatments? OR Have cancer, leukemia, AIDS, or any other immune system problems?		
11. During the past year, have you received a transfusion of blood or plasma or been given immune globulin?		
12. Are you pregnant, planning on becoming pregnant in the next month, or breast feeding?		

For **MEDICARE** or INSURANCE recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to Discount Drug Mart. If a claim rejects, I will be charged cash. For patient reimbursement, the patient must submit their Cash Receipt to their major medical benefits provider.

Physician on Record: Julia Bruner, MD MS 2500 MetroHealth Drive Cleveland, OH 44109

I have read or have had explained to me the information in the Vaccine Information Statement about the vaccine(s) I circled above. I have had a chance to ask questions that were answered to my satisfaction. I attest that I meet the requirements to receive the selected vaccine(s) to be administered I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or the person named below for whom I am authorized to make this request. I agree to receive treatment for any adverse event that may occur after receiving the vaccine(s) while on site. In the event of an accidental post vaccination needle stick to the vaccine administrator, I agree to be contacted for follow up lab work. I have received the VIS Form and the Discount Drug Mart NOPP.

SIGNATURE OF PATIENT (IF PATIENT IS 18 YEARS OF AGE OR OLDER): _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN AUTHORIZING VACCINATION
(IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE): _____
DATE: _____

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Signature and Title of Vaccine Administrator:_____

Printed Name:_____ Date:_____

131: ***Aetna***-Flu; ***Aultcare SERS & STRS***-Flu, Pneumonia; ***Cigna***-Flu, Pneumonia; ***MMO***-COVID, Flu, Pneumonia, Shingrix; ***Summa***-Flu, Pneumonia
3130: Flu, Pneumonia **4130:** COVID **All others:** Rx Benefit or Cash

FOR PHARMACY USE ONLY *CIRCLE/DOCUMENT VACCINES ADMINISTERED, DOSE, AND SITE. DOCUMENT LOT AND EXPIRATION.*								
Vaccine	**Brand Name**	**Manufacturer**	**Age Indication**	**Dose**	**Route**	**Site of Administration**	**Lot**	**Expiration Date**
COVID			18 yrs +	0.5ml 1 2 3	IM	R Arm L Arm		
COVID	Pfizer-Purple Cap/Comirnaty	Pfizer	12 yrs +	0.3ml 1 2 3	IM	R Arm L Arm		
COVID	Pfizer-Orange Cap	Pfizer	5 – 11 yrs	0.2ml 1 2	IM	R Arm L Arm		
Flu-QIV			7 yrs +	0.5ml	IM	R Arm L Arm		
Flu-Cell based	Flublok	Sanofi	18 yrs+	0.5ml	IM	R Arm L Arm		
Flu	Fluzone HD	Sanofi	65 yrs+	0.7ml	IM	R Arm L Arm		
Flu-**LIVE**	Flumist	Astra Zeneca	7-49 yrs	0.2ml	IN	R Nostril L Nostril		
Hepatitis A	Havrix 720 U	GSK	7-18 yrs	0.5ml 1 2	IM	R Arm L Arm		
Hepatitis A	Havrix 1440 U	GSK	19 yrs+	1 ml 1 2	IM	R Arm L Arm		
Hepatitis A	Vaqta 25 U	Merck	7-18 yrs	0.5ml 1 2	IM	R Arm L Arm		
Hepatitis A	Vaqta 50 U	Merck	19 yrs+	1 ml 1 2	IM	R Arm L Arm		
Hepatitis B	Recombivax HB 5 mcg	Merck	7-19 yrs	0.5ml 1 2 3	IM	R Arm L Arm		
Hepatitis B	Recombivax HB 10 mcg	Merck	20+ yrs	1.0ml 1 2 3	IM	R Arm L Arm		
Hepatitis B	Recombivax HB 40 mcg	Merck	Adults-dialysis or immunocompromised	1.0ml 1 2 3	IM	R Arm L Arm		
Hepatitis B	Engerix-B 10 mcg	GSK	7-19 yrs	0.5ml 1 2 3	IM	R Arm L Arm		
Hepatitis B	Engerix 20 mcg	GSK	20+ yrs	1ml 2ml 1 2 3	IM	R Arm L Arm		
Hepatits B	Heplisav-B	Dynavax	18 yrs+	0.5ml 1 2	IM	R Arm L Arm		
Hepatitis A & B	Twinrix	GSK	18 yrs+	1.0ml 1 2 3 4	IM	R Arm L Arm		
HIB	ActHIB	Sanofi	7 yrs+	0.5ml	IM	R Arm L Arm		
HIB	PedvaxHIB	Merck	7 yrs+	0.5ml	IM	R Arm L Arm		
HPV	Gardasil 9	Merck	9-45 yrs	0.5ml 1 2 3	IM	R Arm L Arm		
Meningitis ACWY	Menveo	GSK	11 yrs+	0.5ml 1 2	IM	R Arm L Arm		
Meningitis ACWY	Menactra	Sanofi	11 yrs+	0.5ml 1 2	IM	R Arm L Arm		
Meningitis Group B	Bexsesro	GSK	10 yrs+	0.5ml 1 2 3	IM	R Arm L Arm		
Meningitis Group B	Trumenba	Pfizer	10 yrs+	0.5ml 1 2 3	IM	R Arm L Arm		
MMR-**LIVE**	M-M-R II	Merck	7 yrs+	0.5ml 1 2	SC	R Arm L Arm		
MMR/ Varicella-**LIVE**	ProQuad	Merck	7-12 yrs	0.5ml 1 2	SC	R Arm L Arm		
Pneumonia-PPSV23	Pneumovax 23	Merck	7 yrs+	0.5ml	IM SC	R Arm L Arm		
Pneumonia-PCV13	Prevnar 13	Pfizer	7 yrs+	0.5ml	IM	R Arm L Arm		
Polio	IPOL	Sanofi	7 yrs+	0.5ml	IM SC	R Arm L Arm		
Td	Tenivac	Sanofi	7 yrs+	0.5ml	IM	R Arm L Arm		
Tdap	Adacel	Sanofi	10-64 yrs	0.5ml	IM	R Arm L Arm		
Tdap	Boostrix	GSK	10 yrs+	0.5ml	IM	R Arm L Arm		
Varicella-**LIVE**	Varivax	Merck	7 yrs+	0.5ml 1 2	SC	R Arm L Arm		
Zoster	Shingrix	GSK	50 yrs+	0.5ml 1 2	IM	R Arm L Arm		

SCAN ADMIN FORM AND COPY OF INSURANCE CARD INTO PHARMACY SYSTEM. PLACE RX LABEL ON FORM-DO NOT COVER PERTINENT INFO. FILE IN RX FILES.

UPDATED: 11/22/2021