GET YOUR FLU SHOT!

FLU CLINIC

THURSDAY, OCTOBER 23RD

Where: AHS Cafeteria
When: 10/23 from 230-430p
How: Scan QR Code below to reserve a spot!

Immunizations offered: flu, covid, pneumovax, shingles, tetanus

Scan this QR code to reserve your spot!

ALSO!! You must complete attached consent and bring this along with your insurance card to the clinic

Stop & Shop Pharmacy Vaccine Informed Consent rev 7.2025

Name: Date of Birth: Age: Gender:

Address: City: State: Zip:

Home Phone: Mobile Phone: (**NY Only**) Mother's maiden name:

Primary Care Provider (PCP):_____ PCP Phone Number:_____

PCP Address:_____ I do not currently have a Primary Care Provider ☐

Race: ☐ Asian ☐ Black/African American ☐ White ☐ Other ☐Unknown
☐Native Hawaiian/Other Pacific Islander ☐American Indian/Alaskan Native

Ethnicity: ☐Unknown
☐Hispanic or Latino ☐Not Hispanic or Latino

(NJ Only) I authorize the pharmacist to send copies of my vaccine documents to my PCP. Failure to select one of these boxes will result in the vaccine documents being sent to my PCP, if known, as state laws and regulations require for my state. **YES** ☐ **NO** ☐

Medicare B #:_____ Last 4 SSN: _____
Name as it Appears on Card:

Pharmacy Insurance Information RX ID #: _____
RX BIN: RX PCN: RX Group:

Screening Questionnaire. Ask or contact the pharmacist for any assistance.	**Yes**	**No**
Check any condition/age group below that applies to you so we may screen for needed vaccinations: ☐ Diabetes ☐ Asthma ☐ Smoker ☐ Heart Condition ☐ Lung Condition ☐ 50 or older		
Have you had the following vaccinations? ☐ Influenza ☐ COVID-19 ☐ RSV ☐ Pneumonia ☐ Shingles ☐ Tetanus ☐ Whooping Cough ☐ Hepatitis ☐ Meningitis		
What vaccine(s) are you interested in receiving today? Check all that apply. *A pharmacist will review your answers to determine what vaccines you are eligible for. Availability is subject to change.* ☐ COVID-19 ☐ Flu ☐ RSV ☐ Shingles ☐ Tetanus/Tdap ☐ Pneumonia Other: _____		
Do you feel sick today? (For example: a cold, fever, or acute illness)		
Do you have a history of allergic reaction or allergies to vaccines, vaccine components, medications (including injectable therapies), latex, or foods? *Examples: COVID-19 vaccine, polyethylene glycol (PEG), polysorbate, eggs, yeast, preservatives, phenol, thimerosal, streptomycin, neomycin, polymyxin, gentamicin, gelatin, latex, bovine protein*.		
Have you ever had a severe reaction to any vaccine or after having blood drawn which required medical care including fainting or feeling dizzy?		
Have you received a vaccine in the past 4 weeks?		
Have you ever received a COVID-19 vaccine? When was your last dose:		
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?		
Have you ever been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A), myocarditis or pericarditis?		
Are you receiving a hematopoietic cell transplant (HCT) or CAR-T cell therapies?		
Do you have a chronic health condition such as heart disease, chronic lung disease, chronic kidney disease, diabetes, asthma, blood disorder, complement component deficiency, no spleen, a cochlear implant, or spinal fluid leak?		
Have you had a seizure, brain, or any other neurological disorder, or have you had Guillain-Barré Syndrome?		
Do you, or anyone in your home, or anyone you take care of, have a weakened immune system caused by something such as HIV/AIDS, organ transplant, cancer, or in the past 6 months taken immunosuppressive drugs or therapies? *This includes being treated with prednisone, other steroids, weekly injections, anticancer drugs, or radiation.*		
Have you taken any antivirals (i.e. Tamiflu, valacyclovir) within the past 3 weeks?		
Do you have a bleeding disorder, take a blood thinner, aspirin or any aspirin-containing products, or have a history of Heparin Induced Thrombocytopenia (HIT) or thrombosis with thrombocytopenia syndrome (TTS)?		
Do you have a parent or sibling with an immune system problem?		
Are you pregnant, planning to become pregnant, or breastfeeding?		
For emergency use only, please indicate the patient's weight category: ☐ <33 lbs ☐ 33-66 lbs ☐ >66 lbs		

Pharmacist Use Only Section

Vaccine	Manufacturer	Dose (mL)	Dose # *if applicable	BUD *if applicable	Site of Admin	Vaccine Lot	Vaccine Expiration	Diluent Lot *if applicable	Diluent Exp *if applicable	VIS/EUA/EUI Published Date
					R/L IM/SQ					
					R/L IM/SQ					
					R/L IM/SQ					

Copy sent to provider: YES □ NO □ **Certificate of Immunization given to patient**: YES □ NO □ **Registry checked?** YES □ NO □

I have reviewed the Vaccine Screening Questionnaire to assess the patient for potential contraindications and precautions to the vaccines being administered today. I have confirmed vaccine requested is indicated for the patient. **RPh Initials:** _____ **Admin & VIS/EUA/EUI given on date:** _____

Vaccine Administrator Name (Pharmacist/Intern/Technician): _____ Title: _____

Vaccine Administrator Signature: _____ Date: _____ Lic #:_____

Pharmacist Signature: _____ NPI: _____ Date: _____

Location of Pharmacy/Administration: _____ Phone: _____

Informed Consent:

Patient Name: _____ DOB: _____

Emergency Use Authorization: The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same time of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Emergency Use Instructions: EUI provide information about emergency use of FDA-approved medical products that may not be included in or differ in some way from the information provided in the FDA-approved labeling (package insert).

Consent: I certify that I am: (i) the Patient and at least 18 years of age; or (ii) the patient's personal representative. I consent to, or give consent for, the administration of the vaccine(s) marked on this consent form by a Stop & Shop pharmacist. Where applicable and accepted by state regulations, I consent to my vaccine being administered by a Stop & Shop pharmacy intern or technician. I acknowledge I have the right to ask for a copy of the Stop & Shop Notice of Privacy Practices. I have read, or have had read to me, the Vaccine Information Statement (VIS), EUI Instructions, or EUA Fact Sheet for the vaccines indicated on this form. For COVID-19 Vaccine: I have been provided and have read, or had explained to me, the patient fact sheet corresponding to the COVID-19 vaccination given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand that if a vaccine requires multiple doses, multiple doses of the vaccine will need to be administered (given). I have been given the opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand the benefits and risk of vaccination, and I voluntarily assume full responsibility for any reactions that may result. I have had the opportunity to ask questions, all of which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I understand that I should remain in the vaccine administration area for at least 15 minutes and may need to remain for 30 minutes (if required based on answers to screening questions above) after the vaccination to be monitored for potential adverse reactions. I consent to the emergency administration of epinephrine and/or diphenhydramine, if necessary, to treat an adverse event following vaccine administration. I understand if I experience side effects that I should do the following: call the pharmacy, contact a doctor and/or call 911. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my own expense. I understand that any monies or benefits for administration the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I understand that Stop & Shop Pharmacy may be required to or may voluntarily disclose my health information to my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, health care living facilities, educational institutions, manufacturers, and/or state or federal registries, for purposes of treatment, payment, or other health care operations (such as administration or quality assurance). I also understand that Stop & Shop Pharmacy will use and disclose my health information as set forth in the Notice of Privacy Practices, a copy of which can be obtained in-store, online, or by requesting a paper copy from the pharmacy. I hereby release Stop & Shop Pharmacy and its parent, subsidiary and affiliates, and its officers, employees, and agents, respectively, from any and all liability that might arise from this vaccination on behalf of me, my heirs, and personal representatives**.**

Patient Name (Printed): _____

X_____ Date: _____

Signature of Patient or Patient's Personal Representative**A Personal Representative is someone who has legal authority to make healthcare decisions on the behalf of the patient.*

Patient Guardian (please print): _____Guardian Type: _____