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Giant Food Pharmacy Vaccine Informed Consent rev 12.2025

Store: Type: Date: Conf. #:

Full Name: **Date of Birth (mm/dd/yyyy)**: **Age:** Gender:

Address: City: County: State: Zip:

Home Phone: Mobile Phone:
☐ I would like to sign up for text alerts ☐ I would like a copy of this consent form

Primary Care Provider: Provider Phone Number:
Provider 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: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐ Unknown

Screening Questionnaire. Ask or contact the pharmacist for any assistance.	**Yes**	**No**
1. 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 to receive today.* ☐COVID-19 ☐Flu ☐ RSV ☐Shingles ☐Tetanus/Tdap ☐Pneumonia ☐ Other(s):		
2. COVID-19 Vaccine ONLY: Check "YES" if you have a condition or risk factor for severe COVID-19 outcomes determined by the CDC, including but not limited to a blood disorder, chronic kidney disease, asthma, heart disease, diabetes, mental health conditions (including depression), overweight, physical inactivity, or smoking (current and former). For the comprehensive list of chronic conditions and risk factors, ask your pharmacist, visit the CDC website (https://www.cdc.gov/covid/risk-factors/index.html) or scan the QR code		
3. Do you feel sick today (For example: a cold, fever, or acute illness)?		
4. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?		
5. 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), polymyxin, gentamicin, polysorbate, eggs, yeast, preservatives, phenol, thimerosal, streptomycin, neomycin, gelatin, latex, bovine protein*.		
6. Have you ever had a severe reaction to any vaccine which required medical care including fainting or feeling dizzy?		
7. Have you received any vaccines in the past 4 weeks? ***If yes, list here*:**		
8. Have you ever received a COVID-19 vaccine? ***If yes, list the date of your last dose**:*		
9. Have you ever been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A), myocarditis or pericarditis?		
10. Are you receiving a hematopoietic cell transplant (HCT) or CAR-T cell therapies?		
11. Have you had a seizure, brain, or any other neurological disorder, or have you had Guillain-Barré Syndrome?		
12. 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.*		
13. Have you taken any antivirals (i.e. Tamiflu, valacyclovir) within the past 3 weeks?		
14. 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?		
15. Do you have a bleeding disorder, take a blood thinner, take aspirin or any aspirin-containing products or have a history of Heparin Induced Thrombocytopenia (HIT) or thrombosis with thrombocytopenia syndrome (TTS)?		
16. Do you have a parent or sibling with an immune system problem?		
17. Are you pregnant, planning to become pregnant, or breastfeeding?		
18. Are you receiving a travel consult today for necessary vaccines? ***If yes, please see pharmacist for an intake form***.		
19. For Yellow Fever Vaccine only: Do you have thymus gland disease, or have you had your thymus gland removed?		
20. For emergency use only, please indicate the patient's weight category: ☐ <33lbs ☐ 33-66lbs ☐ >66lbs		
21. Have you had the following vaccinations? ☐COVID-19 ☐Flu ☐RSV ☐Pneumonia ☐Meningitis ☐Shingles ☐Tetanus/Whooping Cough ☐Hepatitis		

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

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

PHARMACIST USE ONLY

Admin Date, VIS Given on	Vaccine & Dose (mL)	Dose #	Lot	EXP Date	BUD	Manufacturer	Injection Site: PLUA - Post Lateral Upper Arm – SQ Deltoid - IM	VIS Revised Date
							IM/SQ L/R Deltoid/PLUA	
							IM/SQ L/R Deltoid/PLUA	
							IM/SQ L/R Deltoid/PLUA	
							IM/SQ L/R Deltoid/PLUA	

Pharmacist/Intern/Technician Name: _____ Title: _____ Date: _____

Patient Name:_____ **DOB (MM/DD/YYYY):** _____

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 Giant pharmacist. Where applicable and accepted by state regulations, I consent to my vaccine being administered by a Giant pharmacy intern or technician. I acknowledge I have the right to ask for a copy of the Giant Notice of Privacy Practices. I have read, or have had read to me, the Vaccine Information Statement (VIS) for the vaccines indicated on this form. 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, all of 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 vaccination(s) 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 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 Giant 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 Giant 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 Giant 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.

Informed Consent	
(For Virgina ONLY) I would like the vaccines I receive today to be reported to my Primary Care Provider. ☐ Yes ☐ No (If an option is not selected, vaccines <u>will</u> be reported to your Primary Care Provider)	
Patient Name (printed): _____	Date of Birth (mm/dd/yyyy): _____
Patient or Patient's Personal Representative Signature*: _____ **A Personal Representative is someone who has legal authority to make healthcare decisions on the behalf of the patient*	Date: _____
Patient Guardian Name (printed): _____	Guardian Type: _____

PHARMACIST USE ONLY CONTINUED
Registry checked to confirm appropriate dose(s) number/product: YES □ NO □ Date: _____ Pharmacist Notes: Patient Weight: _____lbs/kg
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 vaccination is indicated OR evaluated based on shared clinical decision making after consulting with the patient. RPh Initials:
Copy sent to provider: YES □ NO □ Certificate of Immunization given to patient: YES □ NO □ Next Dose Date: _____Next Dose Time: _____
Pharmacist/Intern/Technician Signature: _____NPI: _____
Location of Pharmacy/Administration: _____Phone: _____