# Vaccine Consent Form

**Haworth Apothecary**
**169 Terrace Street, Haworth, NJ 07641**
**201-384-7171**

HAWORTH APOTHECARY
WELLNESS CENTER & GIFT SHOP

## Patient Information

**Form 1 of 2 to be completed**

Last Name | First Name | Date of Birth | Gender

Address | City | State | Zip | County

Cell Phone # | Home Phone # | Email Address

**Please check off the corresponding boxes of the vaccine you would like to receive**

- ◯ **Pfizer Booster**
- ◯ **Moderna Booster**
- ◯ **Influenza**
- ◯ **Shingles**
- ◯ **Pneumonia**
- ◯ **Other:_____**

Scan QR code for more information on Influenza vaccine. If you cannot scan, please see pharmacy for more information

**Date of last dose (MM/DD/YYYY)**

## Insurance Information

**Prescription Insurance:** ◯ Yes ◯ No

Are you the Primary Cardholder? | If No, include the Primary Cardholder's DOB

Prescription Benefit Plan Name | Cardholder ID# | RX Group ID | PCN | BIN

**Medicare Fields:**

◯ Yes ◯ No

Is the Patient age 65 or older or Medicare Eligible?
*Refer to your Medicare Red, White, and Blue card*

Medicare Part A/B ID Number (MBI)
*Note: MBI is required for all patients age 65 and older, or Medicare eligible.*

Haworth Apothecary will send vaccination information upon request from this visit to your doctor/primary care provider using the contact information provided below.
Doctor/Primary care provider name:_____ Fax Number:_____

| COVID-19 Screening Questions | YES | No | Don't Know |
|---|---|---|---|
| 1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19? | ◯ | ◯ | ◯ |
| 2. In the past two weeks, have you had contact with anyone who tested positive for COVID-19? | ◯ | ◯ | ◯ |
| 3. Have you had the new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea? | ◯ | ◯ | ◯ |

| Immunization Screening Questions | YES | No | Don't Know |
|---|---|---|---|
| 1. Are you sick today? (For example: a cold, fever or acute illness) | ◯ | ◯ | ◯ |
| 2. Do you have allergies or reactions to any foods, medications, vaccines or latex? | ◯ | ◯ | ◯ |
| 3. Have you ever had a serious reaction after receiving a vaccination? Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting? | ◯ | ◯ | ◯ |

| Last Name | First Name | Date of Birth | **Form 2 of 2 to be completed** |
|---|---|---|---|

## Immunization Screening Questions (continued)

| | YES | No | Don't Know |
|---|---|---|---|
| 4. Have you had a seizure or a brain or other nervous system problem or Guillain Barre? | ◯ | ◯ | ◯ |
| 5. Do you take anticoagulation medication? For example: Warfarin, Coumadin or other blood thinner | ◯ | ◯ | ◯ |
| 6. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder? | ◯ | ◯ | ◯ |
| 7. Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease or any other immune system problem? | ◯ | ◯ | ◯ |
| 8. Do you have a weakened immune system or in past 3 months, taken medications that weaken it such as cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments? | ◯ | ◯ | ◯ |
| 9. During the past year, have you received a transfusion of blood or blood products, or been give immune (gamma) globulin or an antiviral drug? | ◯ | ◯ | ◯ |
| 10. For women, are you pregnant or is there a chance you could become pregnant during the next month? | ◯ | ◯ | ◯ |
| 11. Have you received any vaccinations or TB skin test in the past 4 weeks? | ◯ | ◯ | ◯ |

**CONSENT FOR SERVICES:** I have been provided with the Vaccine Information Sheet(s) or patient fact sheet corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to me or the person named above for whom I am authorized to make this request.

**AUTHORIZATION TO REQUEST PAYMENT:** I do hereby authorize Terrace Apothecary dba Haworth Apothecary to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid, or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

**DISCLOSURE OF RECORDS:** I understand that Terrace Apothecary dba Haworth Apothecary may be required to or may voluntarily disclose my health information to the physician responsible (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, 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 Terrace Apothecary dba Haworth Apothecary will use and disclose my health information as set forth in the Notice of Privacy Practices (copy is available in-store or by requesting a paper copy from the pharmacy).

**X**

**Signature of patient to receive vaccine (or parent, guardian, or authorized representative)** **Date**

*If signing on behalf of the patient, you are stating that you are authorized to provide the required consents on behalf of the patient.*

| Name of parent, guardian, or authorized representative | Relationship | Phone Number |
|---|---|---|

## As required for state immunization registry reporting.

**Race:** 1 - American Indian or Alaska Native, Tribe:_____ 2 - Asian 3 - Black or African American
4 - Native Hawaiian or Other Pacific Islander 5 - White 6 - Other Race
7 - Prefer not to specify

**Ethnicity:** 1 - Hispanic 2 - Not Hispanic or Latino 3 - Unknown 4 - Prefer not to specify

**Language Spoken:** **Birth Country:** **Plurality:**

## Vaccine Administration Information for Immunizer/Pharmacist use only

1

| Administration Date | Vaccine | | VIS Date | Manufacturer | |
|---|---|---|---|---|---|
| | | IM | | ◯ L ◯ R | |
| **Lot#** | **Exp. Date** | **Route** | | **Site** | **Volume (mL)** |

2

| Administration Date | Vaccine | | VIS Date | Manufacturer |
|---|---|---|---|---|
| | | IM | | ◯ L ◯ R |