BAKERS DRUGS

RX #

VACCINE TYPE

Preferred Administration Site:

□ **Left Deltoid** □ **Right Deltoid**

☐ _____
☐ Flu
☐ Pneumonia
☐ Shingles
☐ COVID

Immunization Screening and Consent Form

Recipient Name (please print)	Date Of Birth	Gender ID **Key:** M – Man/Boy W – Woman/Girl
Address . City State . Zip		Email Address
Parent/Guardian/ Surrogate (if applicable, please print)		Phone
Primary Insurance	Primary Insurance ID#	Primary Insurance Group #
Primary Care Physician Name/Phone Number	Current Pharmacy:	Transfer My Medications to Bakers Drugs: ☐ YES ☐ NO

*If uninsured, you must check the box below to attest that the following information is true and accurate:

☐ I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government-funded health benefit plan.

In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, please provide either (a) a valid Social Security number, (b) state identification number and state of issuance, OR (c) a driver's license number and the state of issuance.

	Screening Questionnaire			
1.	**Are you feeling sick today?**	☐ Yes	☐ No	Tempurature:
2.	**In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a health care provider or health department to isolate orquarantine at home due to COVID-19 infection or exposure?**	☐ Yes	☐ No	□ Unknown
3.	**Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? *If yes, when did you receive the last dose?* _____**	☐ Yes	☐ No	□ Unknown
4.	**Have you ever had an immediate allergic reaction, such as hives, facial swelling, difficulty breathing or anaphylaxis, to any vaccine or shot or to any component of the COVID-19 vaccine, such as polyethylene glycol (PEG) or polysorbate?**	☐ Yes	☐ No	□ Unknown
5.	**Have you had any vaccines in the past 14 days (2 weeks) including flu shot? *If yes, how long ago was your most recent vaccine?* Date: _____**	☐ Yes	☐ No	□ Unknown
6.	**Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?**	☐ Yes	☐ No	□ Unknown
7.	**Are you pregnant or considering becoming pregnant?**	☐ Yes	☐ No	□ Unknown
8.	**Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?**	☐ Yes	☐ No	□ Unknown
9.	**Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?**	☐ Yes	☐ No	□ Unknown
10.	**Do you have a bleeding disorder or are you taking a blood thinner?**	☐ Yes	☐ No	□ Unknown
11.	**Have you received a previous dose(s) of COVID-19 vaccine? If yes: Type of vaccine:_____Dates:_____**	☐ Yes	☐ No	Date: _____ (if applicable)
11.	**FOR COVID VACCINE: If under 65 years of age, do you consent to have at least 1 underlying heath condition outlined below:**	☐ Yes	☐ No	☐ Over 65 Years Old

Table 1: CDC 2025 List of Underlying Medical Conditions That Increase a Person's Risk of Severe COVID-19

▪ Asthma ▪ Cancer ▪ Hematologic malignancies ▪ Cerebrovascular disease ▪ Chronic kidney disease (People receiving dialysis^) ▪ Chronic lung diseases limited to the following: (Bronchiectasis + COPD (chronic obstructive pulmonary disease) + Interstitial lung disease + Pulmonary embolism + Pulmonary hypertension) ▪ Chronic liver disease limited to the following: (Cirrhosis + Nonalcoholic fatty liver disease + Alcoholic liver disease + Autoimmune hepatitis) ▪ Cystic Fibrosis ▪ Children with certain underlying conditions ▪ Diabetes mellitus, type 1 ▪ Diabetes mellitus, type 2* ▪ Disabilities ‡, including Down's syndrome ▪ Epilepsy ▪ Hemophilia ▪ Heart conditions (such as heart failure, coronary artery disease, or cardiomyopathies) ▪ HIV (human immunodeficiency virus) ▪ Mental health conditions limited to the following: (Mood disorders, including depression + Schizophrenia spectrum disorders) ▪ Neurologic conditions limited to dementia ‡ and Parkinson's disease ▪ Obesity (BMI>30 or >95th percentile in children) ▪ Overweight (BMI>25 kg/m2 but <30kg/m2) ▪ Physical inactivity ▪ Pregnancy and recent pregnancy ▪ Primary immunodeficiencies ▪ Sickle cell disease ▪ Smoking, current and former ▪ Substance use disorders ▪ Solid-organ or blood stem-cell transplantation ▪ Tuberculosis

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 undergone the same type of review as an FDA- approved or cleared product. However, the FDA's decision to make the vaccine available is based on the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks. The Novavax COVID-19 vaccine is EUA authorized for those individuals 12 years and older. Please note: FDA approved the Pfizer-BioNTech COVID-19 vaccine in individuals 12 years of age and older; and approved the Moderna COVID-19 vaccine in individuals 18 years of age and older. These vaccines continue to be available under an EUA for certain populations, including Pfizer-BioNTech COVID-19 vaccine for those individuals 6 months through 11 years old, and Moderna COVID-19 vaccine for individuals 6 months through 17 years old and for the administration of an additional dose in the populations set forth in the consent section below.

Emergency Use Instruction
Emergency Use Instructions (EUIs) are issued by the CDC to 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). The COVID-19 vaccine by Pfizer-BioNTech is an FDA-approved COVID-19 vaccine (brand name Comirnaty, mRNA) to prevent COVID-19 in persons 12 years of age and older. CDC is issuing EUI to provide information about use of this vaccine as an additional primary dose in certain immunocompromised persons (12 years of age and older) and a booster dose in certain adults (18 years of age and older) who received certain non-FDA authorized or approved COVID-19 vaccine (e.g., certain vaccines available outside of the United States or from clinical trial participation).

Consent
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 Bakers Drugs 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. Bakers Drugs 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.

Recipient/Surrogate/Guardian (Signature) **Date / Time** **Print Name** **Relationship to patient, if other than recipient**

Area Below to be Completed by Vaccinator			
Which vaccine is the patient receiving today?			
Vaccine Name	Administration	VIS FORM DATE I VIS GIVEN DATE	Manufacturer & Lot Number & Exp
Pfizer/ BioNTech	□ 1st Dose □ 2nd Dose □ 3rd Dose □ Booster		
Moderna	□ 1st Dose □ 2nd Dose □ 3rd Dose □ Booster		
Flu			
Other _____			

Administration Site □ **Left Deltoid** □ **Right Deltoid**

Dosage □ **0.5 ml** □ **0.3 ml**

□ I have provided the patient (and/or parent, guardian or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained.

Vaccinator Signature: _____

Vaccinator Name/Title: _____