

Discount Drug Mart Vaccine Administration and Consent Form

VACCINE RECIPIENT INFORMATION

Patient Name: _____ Date of Birth: ____/____/____ Age: _____

Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ SSN/DL#: _____

Parent/Guardian Name: _____ Parent/Guardian Phone Number: _____

Allergies: _____ Chronic Conditions: _____

Primary Care Physician: _____ PCP Phone Number: _____

Race: White Black/African American Hispanic Asian American Indian/Alaskan Native
 Native Hawaiian/Other Pacific Islander Other: _____ Prefer Not to Answer

Ethnicity: Are you of Hispanic, Latino, or Spanish origin?
 Yes-Please specify: _____ No-Not of Hispanic, Latino, or Spanish origin

Gender: _____

VACCINES REQUESTED (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 RSV 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 above.		
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. I have read or have had explained to me the information in the Vaccine Information Statement (VIS) 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 and 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 Discount Drug Mart NOPP.

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

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: _____

****FOR PHARMACY USE ONLY****

VACCINES ADMINISTERED							
Vaccine Name	Manufacturer	Dose Quantity	Dose Number	Route	Site	Lot	Expiration

Signature and Title of Vaccine Administrator: _____

Printed Name: _____ Date: _____

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- **Aetna Commercial ONLY**-Flu
- **Aultcare SERS & STRS**-Flu, Pneumonia, Shingrix
- **Cigna**-Flu, Pneumonia
- **MMO (NO MEDICARE SUPPLEMENT)**-Flu, Pneumonia, Shingrix
- **PrimeTime**-Flu, Pneumonia
- **Summa**-Flu, Pneumonia

431: MMO-COVID

2083: Aetna B-Flu, Pneumonia

3130: Medicare B-Flu, Pneumonia

3188: Cigna-All Vaccines

4130: Medicare B-COVID

All others: Rx Benefit or Cash

****Always try online card first****

****Scan copies of all current insurance cards into patient profile****

****ICD-10 CODE: Z23****