Stop & Shop Pharmacy Vaccine Informed Consent rev 7.2025

For Flu Vaccines Only

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** ☐

Screening Questionnaire. Ask or contact the pharmacist for any assistance.	**Yes**	**No**
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, 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?		
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?		
If ≤ 17 years of age: Are you currently taking aspirin or salicylate- containing medicine?		
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

Admin Date & VIS Given on Date	Vaccine	Manufacturer	Dose (mL)	Dose # *if applicable	Site of Admin	Vaccine Lot	Vaccine Expiration	VIS Published Date
					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:** _____

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

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

Pharmacist Signature: _____ NPI: _____ Date: _____

Location of Pharmacy/Administration: _____ Phone: _____

Informed Consent

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) 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 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 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 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:** _____