Vaccine Intake Consent Form

Clinic Information (to be completed by Korman Pharmacy® team member)

Clinic ID | Clinic Name | Telephone | Store Number

Address | City | State | Zip

Patient Information

Last Name | First Name | Date of Birth | Gender

Street Address | City | State | Zip

Primary Care Provider (PCP) Name | PCP Phone Number | PCP Fax Number

PCP Address | City | State | Zip

Insurance Information: (For vaccine clinics, please ensure a copy of the patient's insurance card[s] was collected.)

***INDICATES REQUIRED FIELDS**

If vaccine is employer paid with a voucher, enter the following information from the voucher:

Plan Code | Voucher ID | Group ID

In order to receive your vaccination, voucher information must be provided to Korman Pharmacy prior to administration of the vaccine. A hardcopy of the voucher can be printed and presented to the pharmacy or provided electronically on your phone or device.

Prescription Insurance:

Is the patient the primary cardholder? ◯ Yes ◯ No

If no, primary cardholder's Name | Cardholder DOB

*Prescription Benefit Plan Name | *Cardholder ID # | *RX Group ID | *Bin | *PCN

Medicare Fields:

*Is the Patient age 65 or older or Medicare Eligible? ◯ Yes ◯ No

Medicare Part A/B ID Number (MBI)

Note: *MBI is required for all patients age 65 and older, or Medicare eligible. Refer to your Medicare Red, White, and Blue card*

Medical Insurance:

*Medical Insurance Provider | *Cardholder ID # | *Group ID | *Payer ID

Is the patient the primary cardholder? ◯ Yes ◯ No

If no, primary cardholder's Name | Cardholder DOB

***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.

If you have the below information (SSN, ID/driver's license number) please fill in.
If you do not have this information or do not want to share, you may leave it blank and continue filling out the form.

*Social Security Number | or State Identification Number & State | or Driver's License Number & State

If someone else manages health decisions on your behalf, please provide the following:

Caregiver or Financially Responsible Party Name | Relationship | Phone Number

Check all vaccines you wish to receive:

◯ COVID-19 ◯ Tdap ◯ Pneumonia Prevnar 13® ◯ Other (enter below)

◯ Flu ◯ Shingles ◯ Pneumonia Pneumovax 23®

COVID-19 Screening Questions

1.	Do you currently have, or have you in the past 14 days had a 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?	◯ Yes	◯ No ◯ Don't know
2.	Have you tested positive for COVID-19 within the last 14 days?	◯ Yes	◯ No ◯ Don't know

Immunization Screening Questions

1.	Are you sick today? (for example a cold, fever or acute illness?)	◯ Yes	◯ No ◯ Don't know
2.	Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.) or have you ever had a severe allergic reaction (e.g., anaphylaxis) in the past? Example: a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?	◯ Yes	◯ No ◯ Don't know
	Was the severe allergic reaction after receiving a COVID-19 vaccine?	◯ Yes	◯ No ◯ Don't know
	Was the severe allergic reaction after receiving another vaccine or injectable medication?	◯ Yes	◯ No ◯ Don't know
	Was the severe allergic reaction related to receiving Polyethylene Glycol or products containing Polyethylene Glycol?	◯ Yes	◯ No ◯ Don't know
	Was the severe allergic reaction related to receiving Polysorbate or products containing Polysorbate?	◯ Yes	◯ No ◯ Don't know
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?	◯ Yes	◯ No ◯ Don't know
4.	Have you had a seizure or a brain or other nervous system problem or Guillain-Barré?	◯ Yes	◯ No ◯ Don't know
5.	Do you have a bleeding disorder or take blood thinners such as Warfarin/Coumadin?	◯ Yes	◯ No ◯ Don't know
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?	◯ Yes	◯ No ◯ Don't know
7.	Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease or any other immune system problem?	◯ Yes	◯ No ◯ Don't know

8. Are you moderately/severely immunocompromised from a medical condition/ immunosuppressive therapy, including/not limited to: active treatment for solid tumor/ hematologic malignancy, solid organ/stem-cell transplant, primary immunodeficiency syndrome, advanced/untreated HIV infection, or active treatment with high-dose corticosteroids/other immunosuppressive/immunomodulatory biologic agents? ◯ Yes ◯ No ◯ Don't know

9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? ◯ Yes ◯ No ◯ Don't know

10. Are you pregnant or breastfeeding or is there is a chance you could become pregnant in the next month? ◯ Yes ◯ No ◯ Don't know

11. Have your received any vaccinations or TB skin test in the past 4 weeks? ◯ Yes ◯ No ◯ Don't know

COVID-19 Vaccine-Only Screening Questions

1. Is this the patient's ◯ first, ◯ second*, ◯ third*, ◯ booster*, or ◯ other dose*, of the COVID-19 vaccine? *If receiving anything but a first dose, please list date of last dose: _____

   If I am scheduling an appointment for a COVID-19 third dose, I attest that I am eligible for that dose because I am immunocompromised ◯ Yes ◯ No ◯ Don't know

   If I am scheduling a booster shot for the COVID-19 vaccine, I attest that I am eligible for the booster in accordance with ACIP guidelines (Do not use until booster shot is authorized or approved). ◯ Yes ◯ No ◯ Don't know

2. Have you ever received a dose of COVID-19 vaccine? ◯ Yes ◯ No ◯ Don't know

   If yes, which vaccine product? ◯ Pfizer-BioNTech-Comirnaty ◯ Moderna ◯ Johnson & Johnson (Janssen) ◯ Another product: _____

3. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days? ◯ Yes ◯ No ◯ Don't know

4. Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart) either related to or unrelated to receipt of an mRNA COVID-19 vaccine? ◯ Yes ◯ No ◯ Don't know

CONSENT FOR SERVICES: I have received and read (or had read to me) the Patient Fact Sheets and/or Vaccine Information Statements regarding the vaccine. I understand the benefits and risks of vaccination. I voluntarily assume full responsibility for any reactions or consequences that may result. I understand that I should remain in the vaccine administration area for 15 minutes, or longer if directed, after the vaccination to be monitored for potential adverse reactions. In the event of side effects, I understand I should call the pharmacy, my doctor, or 911. I certify that the information provided regarding eligibility for the vaccine is accurate and request that the vaccine be given to me or to the person previously named for whom I am authorized to make this request. If I am signing on behalf of another individual (including a minor), I attest that I have the authority to do so. Please note the following must have the consent of a parent or guardian: Patients in Alabama/Nebraska under 19 years old; patients in South Carolina under 16 years old; and patients under 18 years old in all other states. State of Georgia only: I verify a pharmacist asked for my health history and whether I have had a physical exam within the past year. Health care providers did not identify conditions(s) that would mean I should not receive vaccine(s).

AUTHORIZATION TO REQUEST PAYMENT: I authorize Korman Pharmacy® ("Korman®") to release information to Medicare, Medicaid or any other third party payer as needed and to request payment of authorized benefits to be made on my behalf to Korman, I certify that the information provided about my Medicare, Medicaid or other coverage is correct.

ACCEPTANCE OF FINANCIAL RESPONSIBILITY: Notwithstanding anything previously set forth, I agree that I am responsible for and will promptly pay on demand any and all obligations to Korman Pharmacy including all self-pay balances as well as those charges for services not covered or disallowed by my insurance carrier (for non-COVID-19 vaccines).

DISCLOSURE OF RECORDS: I understand that Korman® may be required to or may voluntarily disclose my health information with respect to this vaccine to my heathcare providers, my insurance plan, health systems and hospitals, and/or state or federal registries. I understand that Korman will use and disclose my health information as set forth in the Korman Notice of Privacy Practices (copy is available in-store, online or by requesting a paper copy from the pharmacy team). If I am receiving through a vaccine clinic, I understand that my name, vaccine appointment date and time will be provided to the clinic coordinator.
State of California only:
I agree to have the California Immunization Registry (CAIR) share my immunization data with the health care providers, agencies or schools.
State of Florida only: Students 18-23 may opt out of the immunization registry by notifying pharmacy prior to administration.

X _____
Signature of patient to receive vaccine (or parent, guardian, or authorized caregiver) 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 Phone Number Relationship

Vaccine Administration Information **Pharmacist/Immunizer use only**

(Please fill out for each vaccine being administered)

_____ If patient's body temperature is 100.4°F or greater, inform them they should not receive the vaccine at this time.

Patient Temperature

Vaccine 1:

Administration Date | Vaccine | VIS Date | Manufacturer | Volume (mL)

Lot # | Exp. Date | Route | ◯ L ◯ R Site

Vaccine 2:

Administration Date | Vaccine | VIS Date | Manufacturer | Volume (mL)

Lot # | Exp. Date | Route | ◯ L ◯ R Site

Vaccine 3:

Administration Date | Vaccine | VIS Date | Manufacturer | Volume (mL)

Lot # | Exp. Date | Route | ◯ L ◯ R Site

Administering Immunizer Name & Title | Administering Immunizer Signature

To be filled out by Immunizer, as required for state immunization registry reporting. Only for states listed.

MS: Check all fields for patients 18 years of age and younger.
OK: Check Race and Ethnicity for all patients. Obtain Next of Kin for patients 18 years of age and younger.

Race:
◯ **1** - American Indian or Alaska Native ◯ **2** - Asian ◯ **3** - Native Hawaiian/Other Pacific Islander
◯ **4** - Black or African American ◯ **5** - White **6** - Other Race

Ethnicity: ◯ **1** - Hispanic ◯ **2** - Not Hispanic or Latino ◯ **3** - Unknown

Next of Kin (18 or younger)

Name | Phone Number | Relationship

Address

State of NJ only

Prescriber Name | Prescriber Address

For CA, MA, MT, NJ, NM, NY, TX
(For CA, this indicator means the registry will not share with Universities, Schools or other agencies.)

Registry Sharing Indicator: ◯ Yes ◯ No