# VACCINE ADMINISTRATION CONSENT FORM

BANGOR DRUG
your hometown pharmacy

## SECTION 1 – INFORMATION ABOUT THE PERSON RECEIVING THE VACCINE

Name: _____ Date of Birth: _____ / _____ / _____ Age: _____
MONTH DAY YEAR

Address: _____ City/State: _____ Zip Code: _____

Cell: (_____)_____ Email: _____ Maiden Name:_____ ☐

Vaccines Needed: COVID Flu Pneumonia Shingles Td Tdap Hep A Hep B Meningitis HPV ☐Other: _____

*Bangor Drug will contact your primary care provider informing them of vaccine(s) given today using the information provided below**

Primary Care Provider Name: _____ Phone: (_____)_____ Fax: (_____)_____

## SECTION 2A – QUESTIONS TO DETERMINE VACCINE ELIGIBILITY (circle YES or NO)

| | |
|---|---|
| 1. In the last 10 days, have you or someone with whom you've been in close contact been diagnosed with COVID-19? | YES NO |
| 2. Are you sick today or do you have any of these symptoms: fever, chills, shortness of breath, body aches, loss of taste/smell | YES NO |
| 3. Do you have any long-term health conditions? *(ex: heart disease, diabetes, asthma, COPD, kidney disease, anemia)* | YES NO |
| 4. Do you have allergies to medications, foods, or latex? *(ex: egg, bovine, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast)* | YES NO |
| 5. Have you ever had an anaphylactic reaction or any other serious allergic reaction to a vaccine OR to polyethylene glycol (PEG) or polysorbate (which can be components of some vaccines)? | YES NO |
| 6. Do you have a seizure disorder, brain disorder, Guillain-Barre Syndrome, or nervous system disorder? | YES NO |
| 7. Do you have a weakened immune system (i.e., HIV, cancer) or take immunosuppressive drugs or therapies (i.e., biologic)? | YES NO |
| 8. During the past year, have you received blood or blood products or been given immune (gamma) globulin? | YES NO |
| 9. Have you had any vaccinations in the past 4 weeks? | YES NO |
| 10. Are you taking blood-thinning medications or do you have a bleeding disorder? | YES NO |
| 11. **FOR WOMEN:** Are you pregnant or breastfeeding or is there a chance you could become pregnant in the next month? | YES NO |

## SECTION 2B – FOR COVID VACCINE ONLY

| | |
|---|---|
| 12. Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies or convalescent plasma)? | YES NO |
| 13. Have you ever received a COVID-19 vaccine? If yes, Manufacturer Name: _____ Date:_____ | YES NO |

14. **Race:** ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Other ☐Prefer not to disclose

**Ethnicity:** ☐Hispanic ☐Non-Hispanic ☐Prefer not to disclose

**Gender:** ☐Male ☐Female ☐Other

## SECTION 3 – PLEASE READ CAREFULLY AND ACKNOWLEDGE WHERE APPROPRIATE

Legal effective July 22, 2016

I hereby give my consent to Bangor Drug (BD) o administer the vaccine(s) (the "Services") I have requested below. **With my initials, I certify that:**

_____ I am: (i) the Patient and at least 18 years of age; (ii) the parent or guardian of the minor Patient; or (iii) the legal guardian of the Patient; or (iv) a person authorized under the law of another state or a court order to consent for the child; OR

_____ The persons identified under (ii), (iii), or (iv), in the preceding sentence are unavailable and I have authority to consent to the immunization of the child because I am a (i) grandparent; (ii) adult brother or sister; (iii) adult aunt or uncle; (iv) stepparent; or (v) another adult who has actual care, control, and possession of the child and has written authorization to consent for the child from a parent, managing conservator, guardian, or other person who, under the law of another state or a court order, may consent for the child; additionally, I certify that I do not have knowledge of any express refusals or withdrawn authorizations of consent and have not been told not to give consent for the child.

I understand that any Protected Health Information ("PHI") I provide BD will only be used or disclosed by BD in accordance with BD's Health Insurance Portability and Accountability Act ("HIPAA") Notice of Privacy Practices. By signing below I acknowledge receipt of such HIPAA Notices of Privacy Practices and consent to the uses and disclosures of PHI described therein. While BD reserves the right to not do so, I consent to BD reporting my immunization information to the State Immunization Registry. Should BD elect to report my immunization history to the Maine State immunization registry, Immpact, I further understand that my immunization information may be accessed by other health care providers, educators, public health representatives, state agencies and certain insurance payers. I further authorize BD to (1) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment or otherwise, (2) submit a claim to my insurer for the below requested items and services, and (3) request payment of authorized benefits be made on my behalf to BD with respect to the below requested items and services. I further agree to be fully financially responsible for any co-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 BD invoices me after the time of service, upon receipt of such invoice. Please note: for non-prescription insurance (i.e. medical/health insurance), your insurance will notify you and Bangor Drug the exact copay/coinsurance amount due once they receive and process the claim. You may receive an invoice for any amounts due, up to and including the total amount of the claim.

**NOT A SUBSTITUTE FOR A PHYSICIAN** I understand that BD Pharmacy representatives are not physicians trained to diagnose and treat medical problems. I acknowledge that the administration of Services does not constitute, and should not be interpreted as, medical advice or opinions substituting for the advice of a physician. I understand that the administration of Services does not create a doctor-patient relationship between myself and BD. I agree to consult a physician if I require medical advice or services at any time.

**RELEASE, IMDEMNITY AND DISCLAIMER** I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s), including COVID-19 vaccine(s). I understand the risks and benefits associated with the below vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements and/or Emergency Use Authorization Fact Sheets 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. I additionally acknowledge that I have received a copy of the BD Pharmacy notice of privacy. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering health care provider. I understand that in the course of the requested vaccine administration, an BD

Pharmacy representative could possibly be exposed to my blood or bodily fluids. In such event, I agree to review and execute the "Bangor Drug Post-exposure Consent for Testing" form.

On behalf of myself, my heirs and personal representatives, I further hereby WAIVE, RELEASE, and AGREE TO INDEMNIFY, DEFEND AND HOLD HARMLESS (including for costs and attorney's fees) Bangor Drug, its staff, agents, employees and corporate affiliates 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 Services listed below, even should such damages or losses result from Bangor Drug's negligence.

**Patient Signature:** _____ **Date:** _____
(Parent or Legal Guardian, if minor)

## SECTION 4 – INSURANCE INFORMATION

| | PHARMACY CARD | MEDICAL CARD |
|---|---|---|
| **Plan/Carrier Name** | | |
| **Member ID #** | | |
| **Group #** | | |
| **RX BIN** | | Not applicable |
| **RX PCN** | | Not applicable |
| Cardholder Name & Date of Birth (if different): | | |

**FOR COVID VACCINE ONLY**

**IF HEB PARTNER**

7-digit PeopleSoft #: _____

**IF UNINSURED**

I attest that I do not have any medical or pharmacy insurance. ☐Yes

Social Security Number: _____
(needed if you do not have insurance)

**FOR MEDICARE PART B ONLY:**

| | |
|---|---|
| **Medicare Number*** | |
| **Last 4 digits of SSN**** | |

*number on red, white, & blue Medicare card
**for insurance verification, if needed

I request payment of authorized Medicare benefits be made on my behalf to Bangor Drug for any service furnished to me by Bangor Drug. I authorize release to the Centers for Medicare and Medicaid Services and its agents any medical information about me needed to determine the payments for related services.

**Name of Medicare Beneficiary**: _____

**Signature:** _____ **Date**: _____

## SECTION 5 – PHARMACY USE ONLY

Temperature checked by (Partner initials): _____

| Vaccine | Brand Name | Amount Administered | Manufacturer | Route | Lot Number / Expiration Date | Site of Administration* |
|---|---|---|---|---|---|---|
| COVID-19 | Janssen | 0.5 ml | Janssen | IM | | RD LD |
| COVID-19 | Moderna | 0.5/0.25 ml | Moderna | IM | | RD LD |
| COVID-19 | Pfizer/Pfizer peds | 0.3 ml/0.2ml | Pfizer | IM | | RD LD |
| **COVID VACCINE:** Vaccine records reviewed (Partner initials):_____ Dose # Provided (circle): 1 2 3 _____ | | | | | | |
| Inactivated Influenza | Fluzone HD | 0.7 ml 0.5 ml | Sanofi Pasteur | IM | | RD LD |
| Inactivated Influenza | Flublok | 0.5 ml | Sanofi Pasteur | IM | | RD LD |
| Inactivated Influenza | Fluad | 0.5 ml | Seqirus | IM | | RD LD |
| Inactivated Influenza | Flucelvax Quad | 0.5 ml | Seqirus | IM | | RD LD |
| Inactivated Influenza | Afluria Quad | | Seqirus | IM | | RD LD |
| Inactivated Influenza | Fluarix Quad | 0.5 ml | GSK | IM | | RD LD |
| Inactivated Influenza | Flulaval Quad | 0.5 ml | GSK | IM | | RD LD |
| Inactivated Influenza | Fluzone Quad | 0.5 ml | Sanofi Pasteur | IM | | RD LD |
| Hepatitis A | Havrix | 0.5 ml / 1 ml | GSK | IM | | RD LD |
| Hepatitis B | Heplisav | 0.5 ml | Dynavax | IM | | RD LD |
| Hepatitis B | Engerix | 0.5 ml / 1 ml | GSK | IM | | RD LD |
| Hepatitis A/B | Twinrix | 1 ml | GSK | IM | | RD LD |
| Herpes Zoster (shingles) | Shingrix | 0.5 ml | GSK | IM | | RD LD |
| HPV-9 | Gardasil 9 | 0.5 ml | Merck | IM | | RD LD |
| Meningococcal (ACWY) | Menveo | 0.5 ml | GSK | IM | | RD LD |
| Measles/Mumps/Rubella | MMR II | 0.5 ml | Merck | SC | | RA LA |
| Pneumococcal-23 | Pneumovax 23 | 0.5 ml | Merck | IM / SC | | RD/RA LD/LA |
| Td (tetanus/diphtheria) | TDVax | 0.5 ml | Grifols | IM | | RD LD |
| Tdap (tet/dip/pertussis) | Boostrix | 0.5 ml | GSK | IM | | RD LD |
| Varicella (chicken pox) | Varivax | 0.5 ml | Merck | SC | | RA LA |
| Other | | | | | | |
| | | | | | | |

* RD - Right Deltoid, LD - Left Deltoid, RA - Right Arm, LA - Left Arm

**VIS**: Flu (inactive/live) 8/6/21, Hep A 7/28/20, Hep B 8/15/19, HPV 8/6/21, MenACWY 8/6/21, MenB 8/6/21, MMR 8/6/21, PCV13 8/6/21, PPSV23 10/30/19, Td 8/6/21, Tdap 8/6/21, Typhoid 10/30/19, Varicella 8/6/21, Zoster 10/30/19, Cholera 10/30/19, DTaP 8/6/21, Hib 8/6/21, Japanese Encephalitis 8/15/19, Polio 8/6/21, Rabies 1/8/20, Rotavirus 10/30/19

| Bangor Drug/ Clinic Location | To Be Completed by Pharmacist | Tech./Student Immunizer (if applicable) |
|---|---|---|
| Corp #: | VIS:_____ | VIS:_____ |
| Address: | Signature: _____ | Signature: _____ |
| City, State, Zip: | **Date of Vaccine Administration**: _____ | |