NY Wegmans Pharmacy Informed Consent/Screening Questionnaire for SARS-CoV2 Immunization

Name:_____Date of Birth:_____Age:_____Gender:_____Phone # _____

Address:_____City_____State: _____ Zip:_____ Allergies: _____ PCP: _____

Race: ☐Native American or Alaskan ☐Asian ☐African American or Black ☐Native Hawaiian or Pacific Islander ☐White ☐Other or Multiracial ☐Prefer not to answer
Ethnicity: ☐Hispanic Origin ☐Non-Hispanic Origin ☐Unknown ☐Prefer not to answer
Which vaccine dose are you receiving today? ☐First dose in series ☐ Second dose in series ☐ Third dose in series
Medical Conditions: Cancer, Chronic kidney disease, COPD, down syndrome, heart conditions, immunocompromised state from solid organ transplant, obesity, pregnancy, sickle cell disease, smoking, type 2 diabetes mellitus ☐Yes ☐No ☐Unknown
Site of Administration: ☐Left Arm ☐Right Arm
***NY Only* COVID Priority Group:** ☐Age ☐3rd dose (Health Reason) ☐Healthcare Provider (Wegmans Pharmacy Staff) ☐Frontline Worker ☐Under 65 with Health Conditions

Screening Questionnaire for Vaccination

The following questions help us determine which vaccines you may be given today. If you answer "Yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your pharmacist to explain it.

		YES	NO	UNKNOWN
1.	*Is the person to be vaccinated sick today?*	☐	☐	☐
2.	*Have you ever received a dose of COVID-19 vaccine?* ***If yes, which vaccine product did you receive (Pfizer, Moderna, Janssen, Other)?***	☐	☐	☐
3.	*In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?*	☐	☐	☐
4.	*Have you been treated with antibody therapy for COVID-19 in the past 90 days (3 months)?* ***If yes, when did you receive the last dose?***	☐	☐	☐
5.	*Have you ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing to any vaccine or shot?*	☐	☐	☐
6.	*Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?*	☐	☐	☐
7.	*Do you take any medications that affect your immune system such as steroids (i.e. cortisone, prednisone), anticancer drugs, or have you had any radiation treatments?*	☐	☐	☐
8.	***Females only**: Is the person to be vaccinated pregnant or is there a chance they could become pregnant during the next month?*	☐	☐	☐

9. ***Patients <18 years old only**: weight of person to be vaccinated (lbs.)* _____

The FDA has approved the use of the Pfizer vaccine for individuals over 16 years old. The FDA has made other versions of the COVID-19 vaccine (Moderna, Johnson & Johnson, and Pfizer (for 5 to 15-year olds) 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 completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

☐ **3rd / Additional Dose (Immunocompromised) Attestation:**
- **By signing this form, I attest that I am immunocompromised and eligible for this additional dose of COVID-19 vaccine, meaning that I meet one of the following** qualifying conditions: receiving active cancer treatment for tumors or cancers of the blood, received an organ transplant and are taking medicines that suppress the immune system, received a stem cell transplant within the last 2 years, moderate or severe immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome), advanced or untreated HIV infection, active treatment with high-dose corticosteroids or other drugs that may suppress your immune system
- **I attest that I have received two (2) previous doses of either Pfizer or Moderna COVID-19 vaccine.**
- **I attest that it has been at least 28 days since I received my second dose of COVID-19 vaccine.**

☐ **Booster Dose Attestation (Moderna and Pfizer as primary series):**
- **By signing this form, I attest that I am eligible for this booster dose vaccine, meaning that I meet one of the following qualifying conditions:** age 65 and older, LTC resident, 50-64 years old with an underlying medical condition (as defined by CDC),18-49 years of age with an underlying condition (as defined by CDC) and individual benefit/risk, 18-64 years of age at increased risk for COVID-19 exposure and transmission because of occupational or institutional setting based on CDC and individual benefit/risk
- **I attest that I have received two (2) previous doses of Pfizer or Moderna COVID-19 vaccine**
- **I attest that it has been at least 6 months since I received my second dose of COVID-19 vaccine**

☐ **Booster Dose Attestation (J&J as primary dose)**
- **By signing this form, I attest that I am eligible for this booster dose of) COVID-19 vaccine, meaning that I meet the qualifying condition: 18 years and older**
- **I attest that I received 1 previous dose of Janssen COVID-19 vaccine at least 2 months ago**

I have read, or have had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be effective. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks (including potential side effects and adverse reactions) of the vaccine(s). I consent to, or give consent for, the administration of the vaccine marked below. I authorize my vaccination documentation to be forwarded to my physician named above, any applicable collaborative prescribing physician and/or the applicable State/Commonwealth Department of Health or its equivalent. I consent to my vaccine record being added to the online state Immunization Information System. I understand that it is recommended that I stay in the general area for 15 to 30 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I hereby release the collaborative prescribing physician for this program, Wegmans Food Markets, Inc., its subsidiaries, affiliates, officers, employees and agents, from any and all liability that might arise from this vaccination on behalf of me, my heirs and personal representatives. I have been provided with a copy of the Wegmans Notice of Privacy Practices. I have been given a CDC COVID vaccine card and upon request can receive a copy of this form. Your health is very important to us. Regular preventative care, including vaccines such as the flu shot, can protect you and your family. From time to time, Wegmans Pharmacy may have helpful information regarding services that may be of interest to you. By signing below, I consent to receive healthcare communications from Wegmans Pharmacy at the telephone number(s) listed above regarding the available vaccines, my prescription(s) and those of my dependent minors, and as a follow up to care that I have received or that my dependent minors have received.

✕ _____

Patient Signature or Legal Representative Relationship of Legal Representative to Patient (if applicable) Date

By signing on this line, I acknowledge that I have received the immunizations listed below and authorize the release of claim information to any third-party agencies involved.

*****For Pharmacy Use Only*****

Vaccine Name	Dose (mL)	Administration	Vaccine Information			Site Given	EUA Fact Sheet Date	Admin Date
			Lot	Expiration	Manufacturer			
☐ Pfizer/BioNTech	☐0.2ml	☐ First Dose						
	☐0.25ml	☐ Second Dose				☐Left Deltoid		
☐ Moderna	☐0.3ml	☐ Third Dose						
	☐0.5ml	☐ Booster Dose				☐Right Deltoid		
☐ Janssen		☐ N/A (Single Dose)						

Form and Questions have been reviewed by Immunizer: **Administering/Supervising Pharmacist Signature:**_____**RPH**

Intern Signature (if applicable): _____