VACCINE CONSENT FORM

Patient Information:

Name: _____ Date of Birth: _____ Age:____ Phone: _____

Address: _____ City:_____ State: ____ Zip: _____

Sex at Birth: ☐ M or ☐ F I want to receive following Vaccine(s):_____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ Black or African American ☐ White ☐ Asian ☐ American Indian/Alaska Native

☐ Native Hawaiian/Other Pacific Islander ☐ Unknown

Medical Condition(s) if any: _____ Weight: _____

Primary Care Physician (PCP) _____ Phone: _____

Address: _____ State:_____ zip: _____

I authorize the pharmacist to send copies of my vaccine documents to my primary care provider: ☐ Yes ☐ No

The following questions will help us determine your eligibility to be vaccinated today. Please ask your pharmacist if any question is not clear.	**Yes**	**No**	**Don't know**
Are you sick today?			
Do you have a long term health problem with heart disease, kidney disease, metabolic disorder (e.g. diabetes), anemia or other blood disorders?			
Do you smoke? Do you have a long term health problem with lung disease or asthma?			
Do you have allergies to medications, eggs, foods, latex or any vaccine components (e.g. neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin or yeast?)			
Have you received any vaccinations in the past 4 weeks?			
Have you ever had a serious reaction after receiving a vaccination?			
Do you have neurological disorders such as seizures or other disorders that affect the brain or have had a disorder that resulted from a vaccine (e.g. Guillain-Barre-Syndrome)?			
Do you have cancer, leukemia, AIDS or any other immune system problem?			
Do you take prednisone, other steroids, or anti cancer drugs or have you had radiation treatments?			
During the past year, have you received a transfusion of blood or blood products, including antibodies?			
Are you a parent, family member, or a caregiver to a newborn infant?			
For Women: Are you pregnant or could you become pregnant in the next 3 months?			
Have you ever received the following vaccines: ☐ Pneumonia ☐ Shingles ☐ Whooping cough ☐ RSV ☐ Hepatitis ☐ HPV			

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Insurance information:

COMMERCIAL PLAN	PHARMACY CARD	MEDICAL CARD
Member ID:		
RX Bin:		N/A
RX PCN:		N/A
RX Group:		
MEDICARE	**MEDICARE PART B**	
Medicare No.		

If uninsured: I attest that I don't have any pharmacy or medical insurance. ☐ Yes

I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid, or other third party payer as needed and request payment of authorized benefits to be made on my behalf to Robinhood Drugs. I acknowledge that my vaccination record may be shared with federal or state or city agencies for registry reporting. I acknowledge that the pharmacist recommends that vaccinated patients should remain in the waiting area for 15 minutes after the administration of the immunization. I acknowledge receipt of the Notice of Privacy Practices for Protected Health Information. I acknowledge that the administration of an immunization or vaccine does not substitute for an annual check up with the patient's primary care physician. I certify my receipt of the services covered by this claim. I request that payment be made on my behalf. I authorize the holder to release medical information about me to any party involved in payment or their agents. I have read, or have had read to me the Vaccine Information Sheet (VIS) or Emergency Use Authorization (EUA) regarding the vaccine. I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine. I consent to, or give consent for, the administration of the vaccine. I fully release and discharge Robinhood Drugs and its parent company, affiliates, subsidiaries, officers, directors, and employees from any liability for illness, injury, loss or damage which may result there from.

Patient Signature: _____ Date:_____

(Parent or guardian, if minor)

PHARMACY USE ONLY

RX Labell here	RX Label here
Vaccine:	Vaccine:
Lot #:	Lot #:
Exp Date:	Exp Date:
Site: ☐ RA ☐ LA	Site: ☐ RA ☐ LA

Onsite ☐ Clinic ☐

Name & Signature of Certified Pharmacist administering Vaccine(s) & providing VIS: _____

License#:_____ NPI#:_____ Date:_____

Name & Signature of Certified Immunizing Technician or Intern administering Vaccine(s): _____