

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

Name: _____ Date of Birth: _____ Age: _____ Gender: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____ Allergies: _____ Primary Care Physician: _____

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/Additional dose Fourth Dose Fifth Dose Sixth Dose

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

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. <i>Is the person to be vaccinated sick today?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. <i>Have you ever received a dose of COVID-19 vaccine?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, which vaccine product did you receive (Pfizer, Moderna, Janssen, Other)?</i>			
<i>If yes, how many COVID vaccine doses have you received?</i> <input type="text"/>			
<i>Date of last dose?</i> <input type="text"/>			
3. <i>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?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. <i>Have you been treated with antibody therapy for COVID-19 in the past 90 days (3 months)?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, when did you receive the last dose?</i>			
5. <i>Have you ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing to any vaccine or shot?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. <i>Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. <i>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?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. <i>Females only:</i> <i>Is the person to be vaccinated pregnant or is there a chance they could become pregnant during the next month?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. <i>Patients <18 years old only:</i> <i>weight of person to be vaccinated (lbs.)</i> _____			

The FDA has approved the use of the Pfizer vaccine for individuals over 12 years and older and the Moderna vaccine for individuals 18 years and older. The FDA has made other versions of the COVID-19 vaccine (Janssen (J&J), Pfizer (for 6 months to 11-year-olds), Moderna (for 6 months to 17-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. In addition, the Centers for Disease Control and Prevention (CDC) has issued Emergency Use Instructions (EUI) to provide information about the use of the Pfizer vaccine as a booster dose in certain individuals 12 years and older and Moderna vaccine in certain individuals 18 years and older who have completed a primary vaccination with certain non-FDA authorized or approved COVID-19 vaccines. Copies of the EUI will be provided to any individual receiving doses under those circumstances.

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 and:** (a) it has been at least 28 days since I received my second dose.
- J&J vaccine recipients: I attest that I have received one (1) previous dose of J&J COVID-19 vaccine and either:** (a) it has been at least 28 days since I received my primary dose; or (b) it has been at least two (2) months since I received a booster dose following my initial dose.

Bivalent Booster Dose Attestation: **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:**

- 5 years and older who have completed their primary series of Pfizer, Moderna, or J&J and it has been at least 2 months since completion of primary series or most recent booster dose

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.

X

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			Route	Site Given	EUA Fact Sheet Date	Admin Date
			Lot	Expiration	Manufacturer				
<input type="checkbox"/> Pfizer/BioNTech	<input type="checkbox"/> 0.2ml	<input type="checkbox"/> First Dose							
	<input type="checkbox"/> 0.25ml	<input type="checkbox"/> Second Dose					<input type="checkbox"/> Left Deltoid		
<input type="checkbox"/> Moderna	<input type="checkbox"/> 0.3ml	<input type="checkbox"/> Third Dose							
<input type="checkbox"/> Pfizer/BioNTech Bivalent	<input type="checkbox"/> 0.5ml	<input type="checkbox"/> Bivalent Booster Dose					<input type="checkbox"/> Right Deltoid		

Form and Questions have been reviewed by Immunizer: _____ Administering/Supervising Pharmacist Signature: _____ RPH
Intern Signature (if applicable): _____