VACCINE REGISTRATION FORM

LAST NAME:_____ TODAY'S DATE_____

FIRST NAME:_____ MIDDLE:_____

AGE:_____ DATE OF BIRTH:_____GENDER:_____

STREET ADDRESS:_____

CITY/TOWN:_____STATE:_____ZIP:_____

PHONE:_____ Last 4 digits SS#_____

RACE: _____ HISPANIC/LATINO:(circle one) YES NO

Email:_____ PREFERRED LANGUAGE:_____

Primary Care Provider & Location:_____

☐ I attest that I am immunocompromised as identified by the CDC: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#considerations-additional-vaccine-dose

CHECK OFF WHICH VACCINE(S) YOU WANT

YOU MAY SELECT MULTIPLE VACCINES

CHECK BOX	Which Arm?	Vaccine Type	Eligibility
	Left - Right	Flu Standard (Flucelvax)	Age 3+
	Left - Right	Flu Senior Dose (Fluad)	Age 65+
	Left - Right	COVID Vaccine **Pfizer/Comirnaty**	Age 12+
	Left - Right	COVID Vaccine **Moderna/Spikevax**	Age 3+
	Left - Right	COVID Vaccine **Novavax**	Age 12+
	Left - Right	Pneumonia (Prevnar20)	Age 50+ **or** patients Age 19+ with a qualifying condition
	Left - Right	Shingles (Shingrix)	Age 50+ **or** patients Age 19+ with a qualifying condition
	Left - Right	Tetanus (TDaP / Boostrix) Tetanus, Diphtheria, Pertussis	Age 10+ (booster every 10 years) and Pregnant women (3rd trimester)
	Left - Right	RSV	All adults 75+ or Adults 60+ with certain chronic conditions. Or you are 32-36 weeks pregnant during September through January

(Turn Over – Form 2-sided)

The following questions will 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 healthcare provider to explain it.

Screening Checklist for Vaccines CHECK A BOX	**YES**	**NO**	DON'T KNOW
1. Are you feeling sick today?	☐	☐	☐
2. Do you have ***severe allergies*** or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, Polyethylene Glycol, Polysorbate, etc.) or have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital? If yes, what are you allergic to?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
7. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
8. Have you had a seizure or a brain or other nervous system problem or have you ever had Guillain Barre Syndrome?	☐	☐	☐
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?	☐	☐	☐
10. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
11. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to Doyle's Corner Drug Inc d/b/a Conley's Drug Store and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the VIS/EUA Fact Sheet 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. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees 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 the vaccine(s) listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry"); and (b) the applicable Provider may disclose my vaccination information to the State Registry for purposes of public health reporting. I acknowledge that I may prevent, by using a state-approved opt-out form the sharing of my vaccination information with any of my other healthcare providers enrolled in the State Registry. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission by providing a completed Opt-Out Form to the applicable Provider and/or my State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's laws or federal law may permit certain disclosures of my vaccination information to State or to Government Agencies as required or permitted by law. I further authorize the applicable Provider to: (a) release my medical or other information, including any communicable disease (including HIV) and mental health information, to, or through, State or Government Agencies, to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-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 the applicable Provider invoices me after the time of service, upon receipt of such invoice. Please note: the cost of vaccines your child will be receiving may not be covered by your health insurance, resulting in significant out of pocket expense. You can avoid this expense by having your child vaccinated at his or her primary care provider.

Sign:_____ **Print**_____ **Date**_____

(Turn Over – Form 2-sided)