_____Vaccine Screening and Consent Form

Heights Specialty Pharmacy
450 Boulevard
Hasbrouck Heights, NJ 07604
201-288-0404

Patient Information

Form 1 of 2 to be completed

Last Name	First Name	Date of Birth	Gender

Address	City	State	Zip	County

Cell Phone #	Home Phone #	Email Address

Primary Care Provider (PCP) Name	PCP Phone Number	PCP Fax Number

PCP Address	PCP City	PCP State	PCP Zip

How many prior doses of this vaccine have you had? _____

Insurance Information

Prescription Insurance: **O** Yes **O** No

Are you the Primary Cardholder?	If No, Include the Primary Cardholder's DOB

Prescription Plan Name	Cardholder ID #	RX Group ID	PCN	BIN

Medicare Fields: **O** Yes **O** No

Is the Patient age 65 or Medicare Eligible?	Medicare A/B ID Number (MBI)

Medical Insurance:

O Yes **O** No

Medical Insurance Carrier	Cardholder ID #	Group ID	Payer ID	Are you the Primary Cardholder?	If No, Include the Primary Cardholder's DOB

If uninsured, you must check the box below to attest that the following information is true and accurate:

O I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government-funded health benefit.

FOR COVID VACCINE ONLY: In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, please provide either (a) a valid Social Security Number, (b) state identification number and the state of issuance, OR (c) a driver's license number and the state of issuance.

Social Security Number	or State Identification Number & State	Or Driver's License Number & State

COVID-19 Screening Questions	Yes	No	Don't Know
1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?	**O**	**O**	**O**
2. In the past two weeks, have you had contact with anyone who tested positive for COVID-19?	**O**	**O**	**O**
3. Have you had any new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?	**O**	**O**	**O**

To be filled out by the immunizer: Patient Temperature: Date Taken:

If patient answers yes to any of these questions or patient's bodily temperature is 100 degrees F or greater, please inform them that they should not receive the vaccine at this time and to contact their primary care provider for next steps and that the vaccine coordinator will be notified.

Form 2 of 2 to be completed

Immunization Screening Questions	Yes	No	Don't Know
1. Are you sick today? (for example: a cold, fever or acute illness)	**O**	**O**	**O**
2. Do you have allergies or reactions to any foods, medications, vaccines or latex?	**O**	**O**	**O**
3. Have you ever had a serious reaction after receiving a vaccination? Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	**O**	**O**	**O**
4. Have you had a seizure or a brain or other nervous system problem o Guillain Barre?	**O**	**O**	**O**
5. Do you take anticoagulation medication? For example: Warfarin, Coumadin or other blood thinner?	**O**	**O**	**O**
6. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder? Specify:_____	**O**	**O**	**O**
7. Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Chrohn's disease or any other immune system problem?	**O**	**O**	**O**
8. Do you have a weakened immune system or in past 3 months, taken medications that weaken it such as cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments?	**O**	**O**	**O**
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drugs?	**O**	**O**	**O**
10. For women, are you pregnant or is there a chance you could become pregnant during the next month?	**O**	**O**	**O**
11. Have you received any vaccinations or TB skin test in the past 4 weeks?	**O**	**O**	**O**

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet(s) or patient fact sheet corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call the pharmacy, contact my doctor, call 911. I request that the vaccine be given to me or the person named above for whom I am authorized to make this request.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize BeJay Pharmacy dba Heights Specialty Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid, or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on the request. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS: I understand that BeJay Pharmacy dba Heights Specialty Pharmacy may be required to or may voluntarily disclose my health information the physician responsible (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems, and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations(such as administration or quality assurance). I also understand that BeJay Pharmacy dba Heights Specialty Pharmacy will use and disclose my health information as set forth in the Notice of Privacy Practices (copy is available from the pharmacy).

X

Signature of patient to receive vaccine (or parent, guardian, or authorized representative) **Date**

If signing on behalf of the patient, you are stating that you are authorized to provide the require consents on behalf of the patient.

Name of parent, guardian, or authorized representative | Relationship | Phone Number

As required for state immunization registry reporting:

Race: 1 – American Indian or Alaska native, Tribe:_____ 2 – Asian 3 – Black or African American
4 – Native Hawaiian or Other Pacific Islander 5 - White 6 – Other Race
7 – Prefer not to specify

Ethnicity: 1 - Hispanic 2 – Not Hispanic o Latino 3 – Unknown 4 - Prefer not to specify

Language Spoken: Birth Country: Plurality:
(1 – single, 2 – twins, 3 triplets or more)

Vaccine Administration Information for Immunizer/Pharmacist use only

Administration Date: Vaccine: VIS Date: Manufacturer:

Lot #: Exp. Date: Route: Site: L R Volume(ml):

Administering Immunizer Name & Title: _____ Administering Signature: _____