

# Vaccination Screening and Consent Form



**PATIENT INFORMATION: Face mask covering both nose and mouth while receiving vaccination(s) is strongly encouraged.**

|                        |                      |           |                            |     |                    |
|------------------------|----------------------|-----------|----------------------------|-----|--------------------|
| PATIENT'S LAST NAME    | PATIENT'S FIRST NAME | MI        | DATE OF BIRTH              | AGE | GENDER (M/F)       |
| ADDRESS                |                      | CITY      | STATE                      | ZIP |                    |
| PATIENT'S PHONE NUMBER | RACE                 | ETHNICITY | PRIMARY CARE PROVIDER NAME |     | PROVIDER PHONE/FAX |

## INSURANCE OR MEDICARE PART B INFORMATION

MEDICARE PART B NOTE: I authorize the Company and Part B Specialists to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf to Part B Specialists as my Medicare Part B provider.

|                                    |                            |                           |                                |
|------------------------------------|----------------------------|---------------------------|--------------------------------|
| INSURANCE OR MEDICARE PART B (Y/N) | NAME AS IT APPEARS ON CARD | INSURANCE/MEDICARE NUMBER | SPARTANNASH EMPLOYEE ID NUMBER |
|------------------------------------|----------------------------|---------------------------|--------------------------------|

## VACCINE(S) REQUESTED

(Example: Annual flu shot, COVID-19, shingles vaccine): \_\_\_\_\_

## VACCINE ELIGIBILITY QUESTIONS

- Are you sick or have a fever today?  Yes  No
- Do you have any allergies to medication(s), food, vaccine components (i.e., eggs, latex, polyethylene glycol, polysorbate), injectable medication and/or a previous vaccine? If yes, please list here:  Yes  No
- Have you ever had a serious reaction, fainted and/or felt dizzy before, during, or after receiving a vaccination or injectable medication, and/or are you feeling anxious today?  Yes  No
- Do you have a long-term health problem with heart, lung (including asthma), kidney, or metabolic disease (e.g., diabetes), a blood disorder, no spleen or non-functioning spleen, a cochlear implant, or spinal fluid leak? Do you use long-term/regular aspirin therapy?  Yes  No
- Have you ever had a seizure disorder, brain disorder, Guillain Barre Syndrome, or other nervous system problem? If the person receiving vaccine is a child, has a sibling and/or a parent had a seizure?  Yes  No
- Are you pregnant, breastfeeding, or is there a chance you could become pregnant during the next month?  Yes  No
- Do you have a weakened immune system (i.e., cancer, leukemia, HIV/AIDS, organ transplant, hematopoietic cell transplant) or any other immune system problem or have a first degree relative with an immune system problem?  Yes  No
- Do you take, or have you taken/received in the past 6 months, medications that weaken your immune system such as prednisone, other steroids; treatment for cancer, HIV, receipt of organ transplant; CART-T-cell therapy; hematopoietic cell transplant (HCT); drugs for the treatment of rheumatoid arthritis, Crohn's disease, or other autoimmune diseases; or have you had radiation treatments?  Yes  No
- During the past year have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug?  Yes  No
- Have you received any vaccinations, including the mpox vaccine, in the past 4 weeks?  Yes  No

## Please complete below if receiving a COVID-19 vaccine:

- Do you have at least one underlying condition that puts you at high risk for severe outcomes from COVID-19?  Yes  No
- Do you have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?  Yes  No
- Do you have a history of myocarditis or pericarditis?  Yes  No

## PATIENT CONSENT

I understand that the provider of this vaccination is SpartanNash Company, Nash Finch Company, Family Fare LLC, MSM Holdco LLC, and/or a SpartanNash Affiliate Pharmacy and will be referred to as "the Company." I have been provided and have read the information sheet about the vaccination(s) I am receiving today. I have had an opportunity to review my answers to the questions above and ask questions that were answered to my satisfaction with the Company's pharmacist. I attest that I have at least one underlying condition putting me at high risk for severe outcomes from COVID-19. The information that I provided above is correct and true to the best of my knowledge. I agree to wait in the vaccination area for at least 15 minutes for observation by the Company's pharmacist. I certify that I am at least 18 years old or am the legal guardian and hereby give my consent to the staff of the Company to administer the vaccine(s) listed below. I understand that it is not possible to predict all possible side effects or complications associated with vaccines. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assignees hereby agree to release, indemnify, and hold harmless the Company its affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccines listed below. I agree that the Company will notify my physician of vaccines received by entering vaccine information into the state immunization registry and/or providing documentation as required by state law and/or Board of Pharmacy rules and regulations. I understand that the Company can only bill certain insurances and that the Company will provide me with this receipt that can be submitted to my insurance company for possible reimbursement. It is my responsibility to work with my insurance company to resolve any issues with payment.

|                                  |                                       |      |
|----------------------------------|---------------------------------------|------|
| PATIENT/LEGAL GUARDIAN SIGNATURE | PATIENT NAME/LEGAL GUARDIAN (PRINTED) | DATE |
|----------------------------------|---------------------------------------|------|

## ADMINISTRATION RECORD: PHARMACY USE ONLY

| VACCINE | MANUFACTURER/NDC | LOT NUMBER | EXPIRATION DATE | DOSE (mL) | ROUTE OF ADMIN | SITE OF INJECTION |    | VIS VERSION |
|---------|------------------|------------|-----------------|-----------|----------------|-------------------|----|-------------|
|         |                  |            |                 |           |                | LA                | RA |             |
|         |                  |            |                 |           |                | LA                | RA |             |
|         |                  |            |                 |           |                | LA                | RA |             |

|  |   |   |
|--|---|---|
| PHARMACY IMMUNIZER SIGNATURE   | PHARMACY IMMUNIZER NAME & TITLE (PRINTED) | PHARMACIST SIGNATURE (IF APPLICABLE)                                    |
| DATE OF VACCINATION/DATE VIS GIVEN   | PHARMACY/CLINIC LOCATION                  | CHECK HERE IF SENT TO PROVIDER <input type="checkbox"/>                 |
|  |   | CHECK HERE IF SENT/ENTERED INTO STATE REGISTRY <input type="checkbox"/> |
| CHECK HERE IF PARENT/LEGAL GUARDIAN INFORMED OF IMPORTANCE OF WELL-CHILD VISITS AND/OR REFERRED <input type="checkbox"/> |   |   |