



Store # \_\_\_\_\_ Address \_\_\_\_\_

RX # \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Telephone \_\_\_\_\_

## Inactive Vaccine Consent and Administration Record

**Patient Information:**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 Primary Care Provider (PCP) Name \_\_\_\_\_ PCP Phone # \_\_\_\_\_  
 PCP Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ PCP Fax # \_\_\_\_\_

**Screening Questions:**

	YES	NO	DON'T KNOW
1. Are you sick today? (For example: a cold, fever or acute illness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.) List _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you take anticoagulation medication? (For example: warfarin, Coumadin or other blood thinner)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. For women: Are you pregnant or nursing? Could you become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. <b>For Shingrix Only:</b> 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**CONSENT FOR SERVICES:** I have been provided with the Vaccine Information Sheet(s) corresponding to the vaccine(s) that I am receiving. I have read or have had explained to me 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 request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

**AUTHORIZATION TO REQUEST PAYMENT:** I do hereby authorize CVS Pharmacy® ("CVS®") to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid 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.

**DISCLOSURE OF RECORDS:** I understand that CVS® may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at CVS (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 CVS will use and disclose my health information as set forth in the CVS Notice of Privacy Practices (copy is available in-store, online or by requesting a paper copy from the pharmacy).

X \_\_\_\_\_  
*Signature of patient to receive vaccine or person authorized to make the request (parent/guardian)*

Date: \_\_\_\_\_

**Vaccine Administration Information:**

Administration Date \_\_\_\_\_ Vaccine \_\_\_\_\_ Manufacturer \_\_\_\_\_  
 Lot # \_\_\_\_\_ Exp. Date \_\_\_\_\_ Route \_\_\_\_\_ Site \_\_\_\_\_  
 Volume (mL) \_\_\_\_\_ VIS Version Date \_\_\_\_\_ Date VIS Given to Pt \_\_\_\_\_

\_\_\_\_\_ Administering Immunizer Name & Title  
 \_\_\_\_\_ Administering Immunizer Signature

Member ID Number: \_\_\_\_\_