Vaccine Clinic Intake Consent Form

Clinic Information (to be completed by CVS Pharmacy® team member)

Clinic ID | Clinic Name | Telephone | Store Number

Address | City | State | Zip

Patient Information

Last Name | First Name | Date of Birth | Gender

Street Address | City | State | Zip

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

PCP Address | City | State | Zip

Insurance Information: (Please ensure a copy of the patient's insurance card[s] is collected.)

***INDICATES REQUIRED FIELDS**

If vaccine is employer paid with a voucher, enter the following information from the voucher:

Plan Code | Voucher ID | Group ID

In order to receive your vaccination, voucher information must be provided to CVS Pharmacy prior to administration of the vaccine. A hard copy of the voucher can be printed and presented to the pharmacy or provided electronically on your phone or device.

Prescription Insurance:

Is the patient the primary cardholder? ◯ Yes ◯ No

If no, primary cardholder's name | Cardholder DOB

*Prescription Benefit Plan Name | *Cardholder ID # | *Rx Group ID | *Bin | *PCN

Medicare Insurance:

*Is the patient age 65 or older or Medicare eligible? ◯ Yes ◯ No

Medicare Part A/B ID Number (MBI)

Note: *MBI is required for all patients aged 65 and older, or Medicare eligible. Refer to your Medicare red, white and blue card.*

Medical Insurance:

*Medical Insurance Provider | *Cardholder ID # | *Group ID | *Payer ID

Is the patient the primary cardholder? ◯ Yes ◯ No

If no, primary cardholder's name | Cardholder DOB

If someone else manages health decisions on your behalf, please provide the following:

Caregiver or Financially Responsible Party Name | Relationship | Phone Number

Check all vaccines you wish to receive:

◯ COVID-19 ◯ Tdap ◯ Pneumonia ◯ Other (enter below)

◯ Flu ◯ Shingles _____

Immunization Screening Questions

1.	Are you sick today?	◯ Yes	◯ No	◯ Don't know
2.	Are you pregnant or planning to be pregnant within the next 3 months?	◯ Yes	◯ No	◯ Don't know
3.	Are you allergic to gelatin, latex, yeast, neomycin or any vaccine ingredient?	◯ Yes	◯ No	◯ Don't know
4.	Have you had a serious reaction after getting a vaccine?	◯ Yes	◯ No	◯ Don't know
5.	Have you ever been dizzy or fainted before, during or after an immunization?	◯ Yes	◯ No	◯ Don't know
6.	Have you had a seizure or other brain or nervous system condition, including Guillain-Barré syndrome (GBS)?	◯ Yes	◯ No	◯ Don't know
7.	Do you have a weakened immune system because of active cancer, HIV/AIDS, transplant or other medical condition?	◯ Yes	◯ No	◯ Don't know
8.	Have you taken medications that affect the immune system or had radiation treatment in the last 6 months?	◯ Yes	◯ No	◯ Don't know
9.	**For COVID-19 only:** Have you received a COVID-19 vaccine in the last two months?	◯ Yes	◯ No	◯ Don't know
10.	**For COVID-19 only:** Have you been diagnosed with a heart condition or Multisystem Inflammatory Syndrome (MIS-A or MIS-C)?	◯ Yes	◯ No	◯ Don't know
11.	**For MMR only:** Have you received immune (gamma) globulin, a blood transfusion or other blood product in the past year?	◯ Yes	◯ No	◯ Don't know
12.	**For MMR only:** Do you have a parent or sibling with an immune system problem?	◯ Yes	◯ No	◯ Don't know
12.	**For MMR only:** Have you received any other vaccinations in the past four weeks?	◯ Yes	◯ No	◯ Don't know
13.	**For MMR only**: Do you have a history of a blood disorder with low platelet count (thrombocytopenia)?	◯ Yes	◯ No	◯ Don't know
14.	**For Pneumonia only:** Do you have a condition or risk factor as defined by the CDC?	◯ Yes	◯ No	◯ Don't know
15.	**For RSV only:** Will you be between 32 and 36 weeks pregnant at the time of your vaccine clinic visit?	◯ Yes	◯ No	◯ Don't know
16.	**For ages 60 to 74 seeking the RSV vaccination:** Are you at an increased risk of severe RSV disease (e.g., you have chronic heart or lung disease or other certain chronic medical conditions or are a resident of a nursing home or other long-term care facility)?	◯ Yes	◯ No	◯ Don't know
17.	**For Shingles only:** Are you immunodeficient or immunosuppressed because of disease or therapy?	◯ Yes	◯ No	◯ Don't know
18.	**For Tdap or TD only:** Do you have a cut, injury, puncture or open wound that prompted getting a tetanus shot?	◯ Yes	◯ No	◯ Don't know

CONSENT FOR SERVICES: I have received and read (or had read to me) the Patient Fact Sheets and/or Vaccine Information Statements regarding the vaccine. I understand the benefits and risks of vaccination. I voluntarily assume full responsibility for any reactions or consequences that may result. I understand that I should remain in the vaccine administration area for 15 minutes, or longer if directed, after the vaccination to be monitored for potential adverse reactions. In the event of side effects, I understand I should call the pharmacy, my doctor, or 911. I certify that the information provided regarding eligibility for the vaccine is accurate and request that the vaccine be given to me or to the person previously named for whom I am authorized to make this request. If I am signing on behalf of another individual (including a minor), I attest that I have the authority to do so. Please note the following must have the consent of a parent or guardian: Patients in Alabama/Nebraska under 19 years old; patients in South Carolina under 16 years old; and patients under 18 years old in all other states. State of Georgia only: I verify a pharmacist asked for my health history and whether I have had a physical exam within the past year. Health care providers did not identify conditions(s) that would mean I should not receive vaccine(s).

AUTHORIZATION TO REQUEST PAYMENT: I authorize CVS Pharmacy® ("CVS®") to release information to Medicare, Medicaid or any other third-party payer as needed and to request payment of authorized benefits to be made on my behalf to CVS®, I certify that the information provided about my Medicare, Medicaid or other coverage is correct.

ACCEPTANCE OF FINANCIAL RESPONSIBILITY: Notwithstanding anything previously set forth, I agree that I am responsible for and will promptly pay on demand any and all obligations to CVS Pharmacy® including all self-pay balances as well as those charges for services not covered or disallowed by my insurance carrier (for non-COVID-19 vaccines).

DISCLOSURE OF RECORDS: I understand that CVS may be required to or may voluntarily disclose my health information with respect to this vaccine to my health care providers, my insurance plan, health systems and hospitals, and/or state or federal registries. I 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 team). State of California only: I agree to have the California Immunization Registry (CAIR) share my immunization data with health care providers, agencies or schools. State of Florida only: Students 18 to 23 may opt out of the immunization registry by notifying pharmacy prior to administration.

X _____

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

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

Name of parent, guardian or authorized representative Phone number Relationship

I further authorize CVS Pharmacy, Inc. and its affiliates, including MinuteClinic®, LLC and its managed entities (collectively "CVS"), to share my vaccination information, test results and other information related to my appointment with one or more of the following: my employer, my employer's vendor or service provider, my educational institution, a business I provide services for (directly or on behalf of another entity) or another third party who has engaged CVS to provide vaccine administration services. I understand that any information released in reliance on this authorization may no longer be protected by federal privacy regulations. I understand that CVS will not condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I can revoke this authorization or obtain a copy of it by calling CVS Patient Support at **1-866-389-ASAP** (1-866-389-2727) but understand my information may already have been disclosed in reliance on this authorization.

X _____

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

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

Name of parent, guardian or authorized representative Phone number Relationship

Vaccine Administration Information **Pharmacist/Immunizer use only**

(Please fill out for each vaccine being administered)

Vaccine 1:

Administration Date	Vaccine	VIS Date	Manufacturer	Volume (mL)
				○ L ○ R
Lot #		Exp. Date	Route	Site

Vaccine 2:

Administration Date	Vaccine	VIS Date	Manufacturer	Volume (mL)
				○ L ○ R
Lot #		Exp. Date	Route	Site

Vaccine 3:

Administration Date	Vaccine	VIS Date	Manufacturer	Volume (mL)
				L ○ R
Lot #		Exp. Date	Route	Site

Administering Immunizer Name & Title

Administering Immunizer Signature

To be filled out by Immunizer as required for state immunization registry reporting and only for states listed.

AL, AK, AR, DC, FL, IA, IN, NJ, NH, NV, NY, RI for Race/Ethinicity
OK & MS: Obtain Next of Kin for patients 18 years of age and younger.

Race:
○ **1** - American Indian or Alaska Native
○ **2** - Asian
○ **3** - Native Hawaiian/Other Pacific Islander
○ **4** - Black or African American
○ **5** - White
○ **6** - Other Race

Ethnicity:
○ **1** - Hispanic
○ **2** - Not Hispanic or Latino
○ **3** - Unknown

Next of Kin (18 or younger)

Name | Phone Number | Relationship

Address

State of NJ only

Prescriber Name

Prescriber Address

For CA, MA, MT, NH, NJ, NM, NY, TX
(For CA, this indicator means the registry will not share with Universities, Schools or other agencies.)

Registry Sharing Indicator: ○ Yes ◉ No