Store Number | Address

Rx Number | City, State, Zip | Phone Number

Vaccine Consent and Administration Record

Patient Information:

Last Name | First Name | Date of Birth

Address | City, State, Zip | Phone Number

Primary Care Provider (PCP) | PCP Phone Number

PCP Address | City, State, Zip | PCP Fax Number

Screening Questions:

Are you sick today? (For example: a cold, fever or acute illness)	◯ Yes	◯ No	◯ Don't Know
Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.) List:	◯ Yes	◯ No	◯ Don't Know
Do you take anticoagulation medication? (For example: warfarin, Coumadin or other blood thinner)	◯ Yes	◯ No	◯ Don't Know
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?	◯ Yes	◯ No	◯ Don't Know
Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?	◯ Yes	◯ No	◯ Don't Know
In the past 3 months, have you taken medications that weaken your immune system such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	◯ Yes	◯ No	◯ Don't Know
Have you had a seizure, brain, or other nervous system problem? (For example: Guillain-Barré syndrome)	◯ Yes	◯ No	◯ Don't Know
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	◯ Don't Know
For women: Are you pregnant or nursing? Could you become pregnant during the next month?	◯ Yes	◯ No	◯ Don't Know
Have you received any vaccinations in the past 4 weeks?	◯ Yes	◯ No	◯ Don't Know

Please have a CVS Health representative contact me to conduct a no-cost health plan comparison to show me my options for 2018 Medicare Part D plans with opportunities to save:

◯ Yes ◯ No If yes, Phone Number _____

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

Caregiver Last Name | Caregiver First Name

Relationship | Phone Number

Signature _____ Date _____

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).

CAREGIVER AUTHORIZATION: I authorize the "Caregiver" designated above to manage my prescriptions, which includes, but is not limited to, submitting prescriptions to be filled, picking up prescriptions, viewing my prescription records and medical profile, discussing my care with Omnicare, accessing financial information related to my prescriptions, providing guidance and direction to Omnicare in connection with my prescriptions, and/or undertaking any activity that I personally could undertake to manage my prescriptions. My Caregiver may manage my prescriptions in person or telephonically. This consent is valid until revoked.

Vaccine Administration Information (for pharmacist use only):

Administration Date | Vaccine | Manufacturer

Lot Number | Expiration Date | Route | Site

Volume (mL) | VIS Version Date | Date VIS Given to Pt

Administering Immunizer Name and Title | Administering Immunizer Signature

Administration Date | Vaccine | Manufacturer

Lot Number | Expiration Date | Route | Site

Volume (mL) | VIS Version Date | Date VIS Given to Pt

Administering Immunizer Name and Title | Administering Immunizer Signature