Giant Food Pharmacy Vaccine Informed Consent rev 7.2025

Store: Type: Date: Conf. #:

Full Name: **Date of Birth**: **Age**: Gender:

Address: City: County: State: Zip:

Email Address: Home Phone: Mobile Phone:

I would like to sign up for text alerts ☐ I would like a copy of this consent form ☐

Primary Care Provider: Provider Phone Number:

Provider Address: I do not currently have a Primary Care Provider ☐

Race: ☐Asian ☐Black/African American ☐White ☐Other ☐Unknown ☐Native Hawaiian/Other Pacific Islander ☐American Indian/Alaskan Native

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Screening Questionnaire. Ask or contact the pharmacist for any assistance.	**Yes**	**No**
What vaccine(s) are you interested in receiving today? Check all that apply. *A pharmacist will review your answers to determine what vaccines you are eligible to receive today.* ☐COVID-19 ☐Flu ☐RSV ☐Shingles ☐Tetanus/Tdap ☐Pneumonia ☐Other(s):		
Do you feel sick today (For example: a cold, fever, or acute illness)?		
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?		
Do you have a history of allergic reaction or allergies to vaccines, vaccine components, medications (including injectable therapies), latex, or foods? *Examples: COVID-19 vaccine, polyethylene glycol (PEG), polymyxin, gentamicin, polysorbate, eggs, yeast, preservatives, phenol, thimerosal, streptomycin, neomycin, gelatin, latex, bovine protein*.		
Have you ever had a severe reaction to any vaccine which required medical care including fainting or feeling dizzy?		
Have you received a vaccine in the past 4 weeks?		
Have you ever received a COVID-19 vaccine? When was your last dose:		
Have you ever been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A), myocarditis or pericarditis?		
Are you receiving a hematopoietic cell transplant (HCT) or CAR-T cell therapies?		
Do you have a chronic health condition such as heart disease, chronic lung disease, chronic kidney disease, diabetes, asthma, blood disorder, complement component deficiency, no spleen, a cochlear implant, or spinal fluid leak?		
Have you had a seizure, brain, or any other neurological disorder, or have you had Guillain-Barré Syndrome?		
Do you, or anyone in your home, or anyone you take care of, have a weakened immune system caused by something such as HIV/AIDS, organ transplant, cancer, or in the past 6 months, taken immunosuppressive drugs or therapies? *This includes being treated with prednisone, other steroids, weekly injections, anticancer drugs, or radiation.*		
Have you taken any antivirals (i.e. Tamiflu, valacyclovir) within the past 3 weeks?		
Do you have a bleeding disorder, take a blood thinner, take aspirin or any aspirin-containing products or have a history of Heparin Induced Thrombocytopenia (HIT) or thrombosis with thrombocytopenia syndrome (TTS)?		
Do you have a parent or sibling with an immune system problem?		
Are you pregnant, planning to become pregnant, or breastfeeding?		
Are you receiving a travel consult today for necessary vaccines? If yes, please see pharmacist for a separate intake form.		
For Yellow Fever Vaccine only: Do you have thymus gland disease, or have you had your thymus gland removed?		

For emergency use only, please indicate the patient's weight category: <33lbs ☐ 33-66lbs ☐ >66lbs ☐

Check any condition/age group below that applies to you so we may screen for other needed vaccinations:

Diabetes ☐ Asthma ☐ Smoker ☐ Heart Condition ☐ Lung Condition ☐ 50 or older ☐

Have you had the following vaccinations?

COVID-19 ☐ Flu ☐ RSV ☐ Pneumonia ☐ Meningitis ☐ Shingles ☐ Tetanus/Whooping Cough ☐ Hepatitis ☐

Medicare B #: Last 4 SSN:

Name as it Appears on Card:

Pharmacy Insurance Information RX ID #:

RX BIN: RX PCN: RX Group:

PHARMACIST USE ONLY

Admin Date/EUA, EUI/VIS Given on	Vaccine & Dose (mL)	Dose #	Lot	EXP Date	BUD	Manufacturer	Injection Site: PLUA - Post Lateral Upper Arm – SQ Deltoid - IM	EUA/EUI/ VIS Revised Date
							IM/SQ L/R Deltoid/PLUA	
							IM/SQ L/R Deltoid/PLUA	
							IM/SQ L/R Deltoid/PLUA	
							IM/SQ L/R Deltoid/PLUA	

Pharmacist/Intern/Technician Name: _____ Title: _____ Date: _____

Patient Name:_____ **DOB (MM/DD/YYYY):** _____

Emergency Use Authorization: The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same time of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Emergency Use Instructions: EUI provide information about emergency use of FDA-approved medical products that may not be included in or differ in some way from the information provided in the FDA-approved labeling (package insert).

Consent: I certify that I am: (i) the Patient and at least 18 years of age; or (ii) the patient's personal representative. I consent to, or give consent for, the administration of the vaccine(s) marked on this consent form by a Giant pharmacist. Where applicable and accepted by state regulations, I consent to my vaccine being administered by a Giant pharmacy intern or technician. I acknowledge I have the right to ask for a copy of the Giant Notice of Privacy Practices. I have read, or have had read to me, the Vaccine Information Statement (VIS), EUI Instructions, or EUA Fact Sheet for the vaccines indicated on this form. For COVID-19 Vaccine: I have been provided and have read, or had explained to me, the patient fact sheet corresponding to the COVID-19 vaccination given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand that if a vaccine requires multiple doses, multiple doses of the vaccine will need to be administered (given). I have been given the opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand the benefits and risk of vaccination, and I voluntarily assume full responsibility for any reactions that may result. I have had the opportunity to ask questions, all of which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I understand that I should remain in the vaccine administration area for at least 15 minutes and may need to remain for 30 minutes (if required based on answers to screening questions above) after the vaccination to be monitored for potential adverse reactions. I consent to the emergency administration of epinephrine and/or diphenhydramine, if necessary, to treat an adverse event following vaccine administration. I understand if I experience side effects that I should do the following: call the pharmacy, contact a doctor and/or call 911. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my own expense. I understand that any monies or benefits for administration the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I understand that Giant Pharmacy may be required to or may voluntarily disclose my health information to my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, health care living facilities, educational institutions, manufacturers, 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 Giant Pharmacy will use and disclose my health information as set forth in the Notice of Privacy Practices, a copy of which can be obtained in-store, online, or by requesting a paper copy from the pharmacy. I hereby release Giant Pharmacy and its parent, subsidiary and affiliates, and its officers, employees, and agents, respectively, from any and all liability that might arise from this vaccination on behalf of me, my heirs, and personal representatives.

Informed Consent	
Patient Name (printed): _____	Date of Birth (mm/dd/yyyy): _____
Patient or Patient's Personal Representative Signature*: _____ **A Personal Representative is someone who has legal authority to make healthcare decisions on the behalf of the patient*	Date: _____
Patient Guardian Name (printed): _____	Guardian Type: _____

PHARMACIST USE ONLY CONTINUED
Registry checked to confirm appropriate dose(s) number/product: YES □ NO □ Date: _____ Pharmacist Notes: Patient Weight: _____ lbs/kg
I have reviewed the Vaccine Screening Questionnaire to assess the patient for potential contraindications and precautions to the vaccines being administered today. I have confirmed vaccine requested is indicated for the patient. RPh Initials: _____
Copy sent to provider: YES □ NO □ Certificate of Immunization given to patient: YES □ NO □ Next Dose Date: _____ Next Dose Time: _____
Pharmacist/Intern/Technician Signature: _____ NPI: _____
Location of Pharmacy/Administration: _____ Phone: _____