HERSHEY Pharmacy & Gift Shop

HERSHEYCARE Continuing Care Pharmacy

HERSHEY Long Term Care Pharmacy

# Covid-19 (SARS-CoV-2) Immunization Consent and Record

| PATIENT'S LAST NAME | PATIENT'S FIRST NAME | MI | GENDER |
|---|---|---|---|
| ADDRESS | CITY | STATE | ZIP |
| 10-DIGIT PHONE NUMBER | BIRTHDATE (MM/DD/YYYY) | ALLERGIES | |
| PRIMARY CARE PHYSICIAN | PHYSICIAN'S ADDRESS | PHYSICIAN'S PHONE NUMBER | |

## COVID - 19 VACCINE AUTHORIZATION FOR 2024-25

" I have been offered the Vaccine Information Sheet (VIS) for the updated Covid-19, 2024-25, vaccine I am consenting to receive. I have been given an opportunity to ask the pharmacist any questions or raise any concerns I have regarding vaccination, and those questions/concerns have been answered to my satisfaction. I understand there are benefits and risks to vaccines and I give my consent to receiving the requested vaccine listed."

" I understand that while they can't be predicted, there are potential side effects of vaccines. These include but are not limited to, redness or soreness at injection site, swelling, fatigue, fever, malaise, flu-like symptoms, allergic reactions, infection, anaphylaxis, and rarely death. I release Hershey Pharmacy, Hershey Long Term Care and HersheyCare pharmacies, C&S Kray, affiliates, and employees from any claims, liabilities or other responsibility relating to injury, illness, death, or other loss related to the receipt of this vaccine. I acknowledge that the pharmacy requests and recommends that I remain in or around the waiting area for 20 minutes following immunization to observe for and triage adverse events or be observed per facility protocol."

"I have received and reviewed a notice for privacy practices and acknowledge its contents. I understand that my primary care provider indicated on this form will be contacted per Pennsylvania regulations related to immunizations by a pharmacist. I understand the information may be uploaded to the state immunization registry (PA-SIIS). I acknowledge that my insurance may not cover any or all of the cost of the vaccine, and I agree to pay the required copayment or cost prior to the administration being completed."

SIGNATURE/LEGAL GUARDIAN | PRINT NAME | DATE (MM/DD/YYYY)

☐ VERBAL AUTHORIZATION ☐ DECLINING VACCINATION AT THIS TIME

AUTHORIZER NAME | RELATIONSHIP TO PATIENT | DATE (MM/DD/YYYY)

FACILITY REPRESENTATIVE

## TO BE COMPLETED BY PHARMACIST ONLY

### VACCINE ADMINISTRATION INFORMATION

VACCINE : _____ ROUTE : _____

EXPIRATION : _____ SITE : _____

LOT # _____

SIGNATURE : _____

RX LABEL AREA ONLY

# Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH _____/_____/_____
month day year

**For parents/guardians:** The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

| | yes | no | don't know |
|---|---|---|---|
| **1.** Is the child sick today? | ☐ | ☐ | ☐ |
| **2.** Does the child have allergies to medicine, food, a vaccine component, or latex? | ☐ | ☐ | ☐ |
| **3.** Has the child had a serious reaction to a vaccine in the past? | ☐ | ☐ | ☐ |
| **4.** Does the child have a long-term health problem with heart, lung (including asthma), kidney, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication? | ☐ | ☐ | ☐ |
| **5.** For children age 2 through 4 years: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months? | ☐ | ☐ | ☐ |
| **6.** For babies: Have you ever been told the child had intussusception? | ☐ | ☐ | ☐ |
| **7.** Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problem? | ☐ | ☐ | ☐ |
| **8.** Has the child ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19? | ☐ | ☐ | ☐ |
| **9.** Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS? | ☐ | ☐ | ☐ |
| **10.** In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? | ☐ | ☐ | ☐ |
| **11.** Does the child's parent or sibling have an immune system problem? | ☐ | ☐ | ☐ |
| **12.** In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug? | ☐ | ☐ | ☐ |
| **13.** Is the child/teen pregnant? | ☐ | ☐ | ☐ |
| **14.** Has the child received vaccinations in the past 4 weeks? | ☐ | ☐ | ☐ |
| **15.** Has the child ever felt dizzy or faint before, during, or after a shot? | ☐ | ☐ | ☐ |
| **16.** Is the child anxious about getting a shot today? | ☐ | ☐ | ☐ |

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

**Did you bring your immunization record card with you?** **yes** ☐ **no** ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.