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

Check all vaccines interested in receiving:

◯ Flu ◯ Shingles (Shingrix®) ◯ Tdap (Boostrix) ◯ Pneumonia Prevnar 13® ◯ Pneumonia Pneumovax® 23 (space out by 1 year for individuals 65+)

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
For women: Are you pregnant or nursing? Could you become pregnant during the next month?	◯ Yes	◯ No	◯ Don't Know

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

Caregiver or Financially Responsible Party Name

Relationship | Phone Number

Address | City, State, Zip

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).

VACCINE ADMINISTRATION INFORMATION (FOR PHARMACIST USE ONLY):

Administration Date	Administration Date	Administration Date	Administration Date
Vaccine	Vaccine	Vaccine	Vaccine
Manufacturer	Manufacturer	Manufacturer	Manufacturer
Lot Number	Lot Number	Lot Number	Lot Number
Expiration Date	Expiration Date	Expiration Date	Expiration Date
Route	Route	Route	Route
Site	Site	Site	Site
Volume (mL)	Volume (mL)	Volume (mL)	Volume (mL)
VIS Version Date	VIS Version Date	VIS Version Date	VIS Version Date
Date VIS Given to Pt	Date VIS Given to Pt	Date VIS Given to Pt	Date VIS Given to Pt
Administering Immunizer Name	**Administering Immunizer Name**	**Administering Immunizer Name**	**Administering Immunizer Name**
Administering Immunizer Title	**Administering Immunizer Title**	**Administering Immunizer Title**	**Administering Immunizer Title**
Administering Immunizer Signature	**Administering Immunizer Signature**	**Administering Immunizer Signature**	**Administering Immunizer Signature**