CVS CAREMARK Store # _____ Address _____
RX # _____ City, State, Zip _____ Telephone _____

Vaccine Consent and Administration Record

Patient Information:

Last Name _____ First Name _____ Date of Birth _____
Address _____ City, State, Zip _____ Phone _____
Primary Care Provider (PCP) Name _____ PCP Phone # _____
PCP Address _____ City, State, Zip _____ PCP Fax # _____

Screening Questions:

	YES	NO	DON'T KNOW
1. Are you sick today? (For example: a cold, fever or acute illness)	☐	☐	☐
2. Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.) List _____	☐	☐	☐
3. Do you take anticoagulation medication? (For example: warfarin, Coumadin or other blood thinner)	☐	☐	☐
4. Have you had a seizure, brain, or other nervous system problem? (For example: Guillain-Barré syndrome)	☐	☐	☐
5. For women: Are you pregnant or nursing? Could you become pregnant during the next month?	☐	☐	☐

CONSENT FOR SERVICES and MEDICAL RECORDS INFORMATION

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet corresponding to the vaccine(s) that I am receiving. I have read or have had explained 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 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.

HIPAA AUTHORIZATION: I voluntarily authorize and direct my health care provider at CVS/pharmacy("CVS") to use and to disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at CVS (standing order provider_____), my Primary Care Physician (_____), my insurance plan, health systems and hospitals, and/or state or federal registries, where required, for purposes of treatment, payment or other health care operations (such as administration or quality assurance) during the term of this HIPAA Authorization ("Authorization"). This Authorization permits CVS to disclose only documents related to the vaccination(s) received today. This Authorization will remain in effect until my health information is disclosed to the recipients identified above. CVS cannot guarantee that any recipient will not redisclose my health information to a third party that may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such a refusal or revocation will not affect the commencement, continuation or quality of my treatment by CVS. I understand that this Authorization will remain in effect until the term of this Authorization expires as noted above or I provide a written notice of revocation to CVS to the address provided in the CVS Notice of Privacy Practices. The revocation will be effective immediately upon CVS's receipt of my written notice, except that the revocation will not have any effect on any action taken by CVS in reliance on this Authorization before it received my written notice of revocation.

X _____ **Date:** _____

Signature of patient to receive vaccine or person authorized to make the request (parent/guardian)

Vaccine Administration Information:

Administration Date _____ Vaccine _____ Manufacturer _____
Lot # _____ Exp. Date _____ Route _____ Site _____
Volume (mL) _____ VIS Version Date _____ Date VIS Given to Pt _____

_____ _____
Administering Immunizer Name & Title Administering Immunizer Signature