Insurance Card: _____ ID: _____ Group: _____ ☐ I do not have insurance

Identification must be provided for COVID Vaccine

☐ Driver's License State___ #_____ ☐ State ID State___ #_____ ☐ I do not have ID

Screening Questionnaire and Consent Form

Patient Information: (Patient to complete)

Patient Name: _____Date of Birth: _____ Age: _____ Phone#: _____

Address: _____ City: _____ State: ____ Zip: _____

Email Address:_____

Gender: M or F Which vaccine(s) would you like to receive today?_____

Ethnicity:☐Hispanic or Latino(1)☐Not Hispanic or Latino(2)☐Unknown(3)
Race:☐American Indian/Alaska Native(4)☐Asian(3)☐Native Hawaiian/Other Pacific Islander(5)
☐Black or African American(1)☐White(2)☐Unknown(6)

Medical Conditions: _____ Enter Weight if less than 110 lbs.: _____
FOR EMERGENCY USE ONLY

Primary Care Physician (PCP): _____ Dr. Phone: _____

PCP address- City _____ State_____Zip Code _____

I authorize the pharmacist to send copies of my vaccine documents to my primary care provider. Yes ☐ No ☐
Failure to select one of these boxes will result in the vaccine documents being sent to my primary care provider, if known, as state laws & regulations require for my state.

The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask your pharmacist to explain it.	**Yes**	**No**	**Don't Know**
Are you sick today?			
Do you have a long term health problem with heart disease, kidney disease, metabolic disorder (e.g. diabetes), anemia or other blood disorders?			
Do you have a long term health problem with lung disease or asthma? Do you smoke?			
Do you have allergies to medications, food (i.e. eggs), latex or any vaccine component (e.g. neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast or yeast)?			
Have you received any vaccinations in the past 4 weeks?			
Have you ever had a serious reaction after receiving a vaccination?			
Do you have a neurological disorder such as seizures or other disorders that affect the brain or have had a disorder that resulted from a vaccine (e.g. Guillain-Barre Syndrome)?			
Do you have cancer, leukemia, AIDS, or any other immune system problem? (in some circumstances you may be referred to your physician)			
Do you take prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?			
During the past year, have you received a transfusion of blood or blood products, including antibodies?			
Are you a parent, family member, or caregiver to a new born infant?			
For women: Are you pregnant or could you become pregnant in the next three months?			
Did you bring your Immunization Record Card with you?			
Are you currently enrolled in one of our medication adherence programs at Rite Aid (OneTrip Refill, Automated Courtesy Refills, or Rx Messaging- Text, Email, Phone)?			
Have you had the following vaccines:	**Yes**	**No**	**Don't Know**
• **Pneumococcal Vaccine-- *you may need two different pneumococcal shots***			
• **Shingles Vaccine**			
• **Whooping Cough (Tdap) Vaccine**			

I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid or other third party payer as needed and request payment of authorized benefits to be made on my behalf to Rite Aid.

- I acknowledge that if my insurance does not cover the cost of administering the vaccine at the pharmacy, then payment must be made at the time of the administration of the vaccine.
- I acknowledge that my vaccination record may be shared with federal or state or city agencies for registry reporting.
- I acknowledge that the pharmacist recommends that vaccinated patients should remain in the waiting area, for 15 minutes, after the administration of the immunization.
- I acknowledge receipt of Rite Aid's Notice of Privacy Practices for Protected Health Information.
- I acknowledge that the administration of an immunization or vaccine does not substitute for an annual check-up with the patient's primary care physician.
- For CA: I acknowledge that Rite-Aid intends to share my vaccination record with the California Immunization Registry (CAIR) and that I have reviewed the 'CAIR Immunization Notice to Patients and Parents' attached to this form.
- For CA: I acknowledge that if I do not want my immunization information shared with other CAIR users, I must complete and submit to CAIR a "Decline or Start Sharing/Information Request Form" obtained either from the pharmacy or downloaded from the CAIR website (http://cairweb.org/cair-forms/).
- I certify my receipt of the services covered by this claim. I request that payment be made on my behalf. I authorize the holder to release medical information about me to any party involved in payment or their agents.
- I have read, or have had read to me the Vaccination Information Sheet (VIS) regarding the vaccine(s). I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s). I fully release and discharge Rite Aid Corporation, its affiliates, officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from.

Patient Signature or legal guardian signature _____

If legal guardian print name _____

PHARMACY USE ONLY

Place RX Label Here

- ○ Influenza Injectable
- ○ Pneumococcal
- ○ Hepatitis B
- ○ HPV
- ○ Varicella
- ○ IPV:
- ○ Meningococcal
- ○ Td
- ○ Hepatitis A
- ○ MMR
- ○ DTaP
- ○ Zoster (Shingles)
- ○ Tdap
- ○ Hepatitis A & B
- ○ Other:

Lot #_____

Exp. Date _____

Site RA or LA- Circle One

Place RX Label Here

- ○ Influenza Injectable
- ○ Pneumococcal
- ○ Hepatitis B
- ○ HPV
- ○ Varicella
- ○ IPV:
- ○ Meningococcal
- ○ Td
- ○ Hepatitis A
- ○ MMR
- ○ DTaP
- ○ Zoster (Shingles)
- ○ Tdap
- ○ Hepatitis A & B
- ○ Other:

Lot #_____

Exp. Date_____

Site RA or LA- Circle One

Clinic – Yes ☐ No ☐

Signature of pharmacist who administered Vaccine(s) and provided VIS to patient: _____

License #: _____ NPI #: _____ Date: _____

Signature of Certified Immunizing Technician or Intern who administered Vaccine(s): _____

Insurance Information required at time of COVID Immunization Administration

For some insurance plans this will be processed by your prescription plan, for others it will be covered by your medical plan. Both will be collected at this time to ensure accurate process completion.

Your Name: First _____ Last _____

Date of Birth _____ Last 4 digits of SSN _____

If over 65 or on Medicare your Medicare part A/B # _____

Prescription Plan information:

Name of Plan _____

Bin # _____

PCN # _____

Group # _____

ID # _____

Relationship circle one: Primary Spouse Child

If not Primary, please provide primary insured's name: _____

Medical Plan information:

Name of Plan _____

Group # _____

ID # _____

Processor control # if on card _____

Relationship circle one: Primary Spouse Child

If not Primary, please provide primary insured's name: _____