BetterHealth Pharmacy
8615 S Hulen St #115
Fort Worth, TX 76123
(682) 708-3499 www.betterhealthfw.com

RX #_____

Vaccine Consent & Administration Record

Pharmacist Immunization Program

*** Required**

PATIENT INFORMATION (VACCINE RECIPIENT)			
Last Name*		**First Name***	
Date of Birth*	**Age***	**Gender*** ☐ M ☐ F	**Phone***
☐ **I want to receive text message alerts regarding my prescriptions.**			**Email**
Address*		**City***	**State*** **Zip***
Race*: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Unknown			**Ethnicity*:** ☐ Hispanic ☐ Non-Hispanic ☐ Unknown
Describe or list any existing medical conditions:			
I want to receive the following vaccination(s)*: ☐ Flu ☐ COVID-19 ☐ Shingles ☐ Other _____			
Parent/Guardian Name (if patient is minor):			**Relationship:**
We will send vaccination information from this visit to your doctor/primary care provider using the contact information provided below.			
Doctor/Primary Care Provider Name			**Provider Phone Number**
Address		**City**	**State** **Zip**

	SCREENING QUESTIONS*	YES	NO	Don't Know
1	Are you feeling sick today? (For example: a cold, fever, acute illness) Today's date: _____	☐	☐	☐
2	Have you been diagnosed with or tested positive for COVID-19 in the last 14 days?	☐	☐	☐
3	In the past 14 days have you been identified as a close contact to someone with COVID-19?	☐	☐	☐
4	Do you have allergies to latex, medications, food, or any vaccine? (examples: polyethylene glycol, polysorbate, eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal) Please list _____	☐	☐	☐
5	Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	☐	☐	☐
6	Do you take anticoagulation medication? (For example: Warfarin, Coumadin or other blood thinners)	☐	☐	☐
7	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?	☐	☐	☐
8	Have you had a seizure, brain, or other nervous system problem?	☐	☐	☐
9	Do you have any chronic health condition such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, obesity, sickle cell disease, diabetes, heart disease? Please list _____	☐	☐	☐
10	Have you received any vaccinations in the last 14 days? Please list _____	☐	☐	☐
11	Have you ever received the following vaccinations? If so, please list date received. ☐ COVID-19: _____ ☐Pneumonia: _____ ☐ Shingles: _____ ☐ Whooping cough: _____	☐	☐	☐
12	**For women:** Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
13	**For COVID-19 vaccine only:** Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies or convalescent plasma)?	☐	☐	☐
	ANSWER THE FOLLOWING QUESTIONS ONLY IF YOU ARE RECEIVING: CHICKENPOX, MMR® II, SHINGLES, VAXCHORA®, YELLOW FEVER			
14	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
15	Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☐	☐
16	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
17	Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your thymus removed? (yellow fever only)	☐	☐	☐
18	Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)	☐	☐	☐
19	Have you consumed any food or drink in the last hour? (Vaxchora® only)	☐	☐	☐
20	Have you taken antibiotics in the last 14 days or antimalarials in the last 10 days? (Vaxchora® only)	☐	☐	☐

INSURANCE INFORMATION

PHARMACY CARD	
ID	
RX BIN	
RX PCN	
Group	

MEDICARE	
Medicare No.*	
SSN	

* Number on red, white, and blue card

Are you the cardholder? ☐ YES ☐ NO

If no, please provide cardholder's name, date of birth (MM/DD/YYY) & relationship:

_____

COVID-19 VACCINATION ONLY

☐ **If uninsured:** I attest that I do not have any medical or pharmacy insurance.

Driver's License	
Issuing State	

Initial Here: _____

FOR PHARMACY USE ONLY

☐ Insurance Search ☐ In RXQ ☐ Uninsured

CONSENT FOR SERVICES, HIPAA PRIVACY INFORMATION AND MEDICAL RECORDS

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to Better Health Pharmacy and the licensed healthcare professional providing services, as applicable (each an "applicable Provider"), to administer the vaccine(s) and/or provide the medical treatment(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s) and/or medical treatment(s). I understand the risks and benefits associated with the above vaccine(s) and/or treatment(s) and have received, read and/or had explained to me the EUA Fact Sheet on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) and/or medical treatment(s) listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Centers for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the applicable Provider: (a) the disclosure of my vaccination information by the applicable Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and, to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies, State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws or federal law may permit certain disclosures of my vaccination information to or through the State HIE or to Government Agencies as required or permitted by law. I further authorize the applicable Provider to: (a) release my medical or other information, including any communicable disease (including HIV) and mental health information, to, or through, the State HIE or Government Agencies to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice. Better Health Pharmacy may contact you, including by autodialed and prerecorded calls and texts, at any time, using the contact information provided in your patient record regarding health and safety matters, such as vaccine reminders.

Signature of patient or guardian: _____ **Date:** _____

- FOR PHARMACY USE ONLY -

PRODUCT	MANUFACTURER	VOL (ML)	DOSE #	SITE	ROUTE	LOT #	EXP DATE	VIS VER. DATE
☐ COVID SPIKEVAX	☐ Moderna	0.5		L / R	IM		/ /	/ /
☐ FLUCELVAX	☐ Sequirus	0.5		L / R	IM		/ /	/ /
☐ FLUAD	☐ Sequirus			L / R	IM		/ /	/ /
☐ AFLURIA	☐ Sequirus			L / R	IM		/ /	/ /
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Administering Immunizer:	**Administration Date:**
Signature: _____	**Date VIS Given to Patient:**

Affix Rx Label

NOTES