OMRO PHARMACY

328 E Main St Omro WI, 54963
920-685-5041

Vaccine Consent and Administration

Patient Name:_____ DOB:_____

What vaccine(s) are you seeking today?: [ ] Influenza [ ]Pneumonia [ ] COVID [ ] Other:_____

Have you had other vaccines in the past 2 weeks? [ ]No or [ ]Yes-If yes, what was given and when:_____

Please answer the following questions:			
1. Are you sick today? (for ex: a cold, fever, acute illness)	**[ ]No**	or	**[ ] Yes**
2.Do you have allergies to medications, foods, or any vaccines? (for ex: eggs, gelatin, neomycin, Thimerosal, Latex, etc.) Please list:_____	**[ ]No**	or	**[ ] Yes**
3. 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?	**[ ] No**	or	**[ ]Yes**
4. Do you have cancer, leukemia, AIDS, or any other immune system problems?	**[ ]No**	or	**[ ]Yes**
5. For women: are you pregnant or is there a chance you could become pregnant during the next month?	**[ ]No**	or	**[ ]Yes**
6. Have you ever had a reaction after receiving a vaccine, including feeling faint or dizzy?	**[ ]No**	or	**[ ]Yes**

Please read ALL of the following 3 statements, if consent is given, please sign and date below.

1. I have been provided with the Vaccine Information Sheet(VIS) or EUA fact sheet and/or been provided with information regarding to the vaccine I am receiving.

2. I understand all the benefits and risks of the vaccine and have had the chance to ask questions regarding it. I voluntarily assume full responsibility for any reactions that may result.

3. I request that vaccine be given to me and authorize and direct this health care provider to use or disclose my health information during the term of this authorization to the physician responsible for this protocol of specific health information of people vaccinated by this provider(standing order practitioner), my Primary care Physician(PCP)_____, my insurance plan and/or state federal registries, where required for purposes of treatment, payment or other health care operations. This only allows this provider to disclose the following medical records: only documents related to the vaccination received today. This authorization will remain in effect until my health information to the recipient identified above; my health care provider cannot guarantee that the recipient will not disclose my health information to a third party. The third party 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 or revoke this authorization at any time. I understand that this authorizations will remain in effect until the term of this authorization expires or I proved a written notice of revocation to my health care provider. The revocation will be effective immediately upon my health care provider's receipt of my written notice.

Signature of patient :_____ Date:_____

Signature of parent or guardian:_____ Date:_____
(if patient is under age 18)

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To be completed by Vaccine Administration staff

Administration date:_____

[ ] Influenza(once per flu season) Brand/NDC:_____

[ ]Pneumonia(once every 5 years) Brand/NDC:_____

[ ]COVID 19 1st Dose:
Brand: [ ]Pfizer Biontech(codes: 91300 &0001A) [ ]Moderna(Codes: 91301 & 0011A)
[ ] Asteazeneca(Codes: 91302 & 0021A)

[ ]COVID 19 2nd Dose:
Brand: [ ]Pfizer Biontech (codes: 91300 &0001A) [ ]Moderna(Codes: 91301 & 0011A)
[ ] Asteazeneca(Codes: 91302 & 0021A)

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Vaccine Intake Questionnaire

Patient Name:_____ DOB:_____ Gender: [ ] F or [ ] M

Ethnicity: [ ] American Indian/Alaska Native [ ] Asian [ ] Black/African American [ ] Hispanic/ Latino [ ] White [ ] Other_____

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

Phone #:_____ Email:_____

Are you a facility Resident? [ ] N or [ ] Y.....if yes list facility name:_____ Rm #:_____

Responsible Party Name:_____ Address:_____ Phone #:_____

SSN:_____ Medicare #:_____

Medical Insurance Payer:_____ Policy #:_____ Grp #:_____

Payer Address:_____ Phone#:_____

Insured:_____ DOB:_____ Relationship:_____

Prescription drug Plan:_____ Rx Bin:_____ Rx PCN:_____

Plan ID #:_____ Rx GRP #:_____

Insured:_____ DOB:_____ Relationship:_____

List of any known allergies:_____

_____

List any known Medical Conditions:_____

_____

Primary Care Physician:_____ Phone #:_____

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

HIPAA Privacy Information and Medical Records

1) I have acknowledged that I have received the provider's Inc Notice of Privacy Practices which may be provided at my request.
2) For Medicare, Medicaid, or Insurance Billing: I authorize this provider to release information and request payment, I understand that the information given by me in applying for payment if correct.
3) I authorize the release of all records to act on this request and I request that payment of benefits be made on my behalf.

Signature of Patient or Guardian:_____ Date:_____