Tops Pharmacy # Address Phone

COVID Vaccine Consent and Administration Record

Information about patient receiving vaccine (Please Print):

Last Name	First Name	Middle Initial	Date of Birth / /	Gender

Street Address	City, State, Zip Code	Phone #

Allergies	Email address

Ethnicity (circle one)

Hispanic Origin Unknown

Non-Hispanic Origin Declined

Race (circle one)

Alaskan African American

Asian Black Declined

Multiracial Native Hawaiian or Pacific Islander

White Other _____

Name of Primary Healthcare Provider (Primary Doctor) **Office Address or Phone Number**

Insurance Information: **Rx BIN:** **RX PCN:**

Company Name: **Rx Group:** **Rx ID:**

Please answer each question by checking Yes or No	**Yes**	**No**
1. Are you feeling sick today?	☐	☐
2. In the last 14 days have you had any of the following: fever (100.4°F or higher), shortness of breath, muscle aches, chills, cough, sore throat, diarrhea, new loss of taste or smell or confirmed or suspected COVID-19 infection?	☐	☐
3. In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate at home due to COVID-19 infection, exposure or recent travel?	☐	☐
4. Have you been treated with antibody therapy for COVID-19 in the past 90days (3 months)? *If yes, when did you receive the last dose?*	☐	☐

****If you answered yes to questions 1, 2, 3 or 4 please let the pharmacist know before completing the rest of this form****

Contraindications and Precautions - Please answer each question by checking Yes or No	**Yes**	**No**
5. Have you ever had an immediate allergic reaction? *Examples: hives, facial swelling, difficulty breathing, anaphylaxis*	☐	☐
6. Have you ever had a serious reaction after receiving a vaccine or injectable therapy?	☐	☐
7. Are you allergic to polyethylene glycol (PEG), polysorbate or any other ingredient in any COVID-19 vaccine?	☐	☐
8. Have you had any vaccines in the past 14 days?	☐	☐
11. Do you have any medical conditions that affect your immune system? *Examples: leukemia, any type of cancer, HIV/AIDS, autoimmune conditions*	☐	☐
11. Do you take any medications that affect your immune system? *Examples: cortisone, prednisone or other steroids, anticancer drugs, radiation treatments*	☐	☐
13. Do you have a bleeding disorder, or are you taking a blood thinner?	☐	☐
14. FOR WOMEN – Are you pregnant or considering becoming pregnant?	☐	☐

I understand that vaccine supply is currently limited and, therefore, subject to strict prioritization in accordance with Centers for Disease Control and New York State Department of Health directives. With that understanding, I hereby certify under penalty of law that I qualify to receive this vaccine in the following capacity:

_____

(Qualification or high-risk group currently eligible for vaccine)

Form of proof shown:

Initials of Provider verifying proof: _____

Is this your first dose of COVID-19 vaccine? Yes or No

If no, Date of 1st dose __/__/__ Manufacturer_____

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Consent

I have been provided with and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if my vaccine requires two doses, I will need to be administered (given) two doses in order for it to be effective. I have had a chance to ask questions which were answered to my satisfaction (and [if applicable] ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I voluntarily assume full responsibility for any reactions that may result from receiving this vaccine. I, for myself (or the person named above for whom I am authorized to make this request and provide surrogate consent), my (or their) heirs, executors, personal representatives and assigns, hereby release Tops Markets, LLC, its affiliates, subsidiaries, divisions, franchisees, directors, contractors, agents and employees, from any and all claims including any loss, injury, death or damage suffered, arising out of, in connection with, or in any way related to my receipt of this vaccine.

I acknowledge that Tops Markets, LLC is required to release my immunization and identifying information to the New York State Immunization Information System (NYSIIS). I understand the purpose of NYSIIS is to assist in my medical care and to record the immunizations that I have had or will receive in the future. My immunization information may potentially be used by the New York State Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes, and may be released to the following: myself, my health insurance plan, state and local health departments, the school that I am registered to attend, and authorized medical providers that deliver my medical care.

I further acknowledge that Tops Markets, LLC may be required to report my immunization information to my primary care provider. I hereby voluntarily authorize and direct my pharmacist at Tops Markets, LLC 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 at Tops Markets, LLC, the standing order provider, my Primary Care Provider, my insurance plan or employer and/or state or federal registries, where required for purposes of treatment, payment or other health care operations (such as administration or quality assurance). This Authorization permits Tops Markets, LLC to disclose the following medical records: only documents related to the vaccination received today. This Authorization will remain in effect until my pharmacist discloses my health information to the recipient(s) identified above; my pharmacist cannot guarantee that the recipient will not redisclose 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 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 my pharmacist. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider. The revocation will be effective immediately upon my pharmacist's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation. I acknowledge that I have received, or have been offered a copy of the Tops Markets, LLC Notice of Privacy Practices.

I understand that there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health plan, Medicare or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes. I certify that the information given by me regarding my medical coverage and in applying for payment under Medicare, if applicable, is correct. I request that the payment of authorized benefits be made on my behalf.

Name of person receiving the vaccine (please print):_____

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

Vaccine Administration Information (to be completed by Pharmacy):

Date	Product	Manufacturer	Lot #	Exp. Date
Route	Admin Site	Dose (ml)	Administrator Name	
#	NDC	Date of VIS Given:	Prescriber	