HARRIS TEETER PHARMACY
09700495
8345 CREEDMOOR RD
RALEIGH NC 27613

Vaccine Consent Form Harris Teeter - NC

☐ RPh/Tech Name: _____
☐ Phone/Fax Date: ___/___/___
☐ Phone/Fax Time: ___:___AM/PM
☐ Registry Date: ___/___/___

(Internal/Off Site Clinic Information)

GLOVER

First Name: NICHOLAS MI: Last Name: GLOVER Date of Birth: 12/14/1990 Sex Assigned at Birth: Male Age: 30 Weight:

Mobile Phone: (419) 206-8715
Race: ☐Black or African American ☐American Indian or Alaska Native ☐Hispanic/Latino ☐White ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐Other ☐Not specified
Ethnicity: ☐Not Hispanic/Latino ☐Hispanic/Latino ☐Not specified

Home Address: 8609 WELLWSLEY WAY City: RALEIGH State: NC Zip Code: 27613 Mother's Name: (first/maiden)

Primary Healthcare Provider: Provider Address: Provider Phone: Provider Fax:

Are you covered by commercial or federally funded healthcare insurance? ☐YES ☐NO If **NO,** Provide State Issued ID (preferred) or Social Security Number: _____

If **YES,** provide Insurance Carrier: If **YES,** provide Cardholder ID: If **YES,** provide Group Number:

I WANT TO BE PROTECTED FROM THE FOLLOWING (PLEASE CHECK ALL THAT APPLY): ☑FLU ☐HEPATITIS A ☐HEPATITIS B ☐HPV ☐ *MEASLES/MUMPS/RUBELLA (MMR)** ☐MENINGITIS ☐PNEUMONIA ☐SHINGLES ☐TDAP ☐ *VARICELLA** ☐ COVID-19: PRODUCT_____ OTHER (PLEASE SPECIFY): _____

Please answer the following questions to help us make sure the vaccine is right for you:

	Yes	No
1. Do you have any of the following symptoms today? Fever, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea	☐	☑
2. In the past 14 days, have you had a fever or been exposed to or diagnosed with COVID-19, regardless of symptoms?	☐	☑
3. Do you have any allergies to medications, food (e.g. eggs), latex or a vaccine component (e.g. gelatin, neomycin, polymyxin, yeast, thimersol, polyethylene glycol, etc.)? If yes, please list :_____	☐	☑
4. Have you ever had a serious reaction (including fainting) after receiving a vaccination?	☐	☑
5. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?	☐	☑
6. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohn's disease?	☐	☑
7. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☑
8. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	☐	☑
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug, or received COVID-19 antibody treatment?	☐	☑
10. **For Women,** are you pregnant, breastfeeding or is there a chance you could become prenant during the next month?	☐	☐
11. Has any physician or other healthcare professional cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a physician's office or hospital?	☐	☑
12. Have you received any vaccinations in the past 4 weeks?	☐	☑
13. **For Tdap and adult Td (ONLY),** do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?	☐	☑
14. Have you had the vaccine(s) you are receiving today before? If yes, which vaccine product?	☐	☑
15. Do you have any current medical conditions? If yes, please list your condition(s):_____	☐	☑

ALL VACCINES

***An immunization must NOT be given if there is a YES answer to question 11 or 13, any other affirmative answers should have clinical due diligence per protocol.**

I certify that I am: (i) the Patient and at least 18 years of age; (ii) the parent or legal guardian of the minor Patient; or (iii) the legal guardian of the Patient. Further, I hereby give my consent to the health care provider of Harris Teeter Grocery Stores to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccines(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read, and/or had explained to me the Vaccine Information Statements (VIS) and the FDA's Emergency Use Authorization (EUA) 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 acknolwedge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering health care provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Harris Teeter Grocery Stores 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 vaccine(s) listed above. I authorize Harris Teeter Grocery Stores to release medical or other information to my health care professionals, Medicare, Medicaid or other third party payor necassary to effectuate care or payment and request that payment of authorized benefits be made on my behalf to Harris Teeter Grocery Stores with respect to the vaccine(s) listed above. I understand if my claim to the HRSA Uninsured Fund is not reimbursed because it is determined that I have third-party insurance, I authorize Harris Teeter, LLC to utilize my protected health information and other identifiers to try and identify and bill my insurance.

X _____ Date: 11/11/21
(SIGNATURE OF PATIENT OR LEGAL GUARDIAN, IF PATIENT UNDER AGE 18) (FOR LEGAL GUARDIANS ONLY: PRINT NAME and RELATIONSHIP)

FOR INTERNAL USE ONLY

☐ If <18, recommend Well-Child Visit

☐ **REQUIRED:** obtained verbal consent to treat prior to administration

Vaccine Name: NICHOLAS . GLOVER DoB:12/14/1990 Date:11/11/2021 loc:097-495 Prod:FLUBLOK QUAD 2021-2022
Manufacturer:_ Mfr:SANOFI-PA Exp: 06/30/2022
Dose:___ Ser Lot:QFAA2132 Qty:0.5ml NDC:49281-0721-10 _____
Vaccine Exp. Date: _____
Diluent Lot #/Exp. Date: _____
Injection Site: **LEFT/RIGHT; ARM/THIGH** Route: **IM** or **SubQ**
VIS or EUA Given: 11/11/21 Version Date: 8/6/21

☐ **REQUIRED:** counsel patient remain near location for 15-30 min.

Vaccine Name:_____
Manufacturer:_____
Dose:___ Series#: ___ of ___Vaccine Lot #: _____
Vaccine Exp. Date: _____
Diluent Lot #/Exp. Date: _____
Injection Site: **LEFT/RIGHT; ARM/THIGH** Route: **IM** or **SubQ**
VIS or EUA Given: __/__/__ Version Date:__/__/__

Supervising RPh/Lic#:_____ (if required) Immunizer: _____ Date Administered: 11/11/21 Time: 3:30 AM/PM

Printed copies are for reference only