202 N. 3rd Ave. W. Newton, IA 50208 | 641-792-6119 | Fax: 641-792-0337
4440 NE Hubbell Avenue Des Moines, IA 50317| 515-557-1810| Fax: 515-557-1809
www.progressindustries.org

September 27, 2021

Dear Parents, Guardians, Family Members and Individuals in Services:

P.I. has partnered with Hy-Vee Pharmacy to administer the **Pfizer COVID-19 booster vaccine** and the **seasonal influenza vaccine** to individuals in services. We will hold a **vaccination clinic** on Monday, October **18 at P.I.'s Jasper County** – Newton administrative office and on Tuesday, **October 19 at P.I.'s Polk County – Des Moines** administrative office.

A COVID booster shot is an additional dose of a vaccine given after the protection provided by the original shot(s) has begun to decrease over time. According to the CDC, the COVID booster can be administered as early as 6 months from initial vaccination. The CDC recommends a third dose of the two-shot vaccines (Pfizer and Moderna) for people with underlying conditions, those over 65, Health Care Workers and those who have high-risk exposure to unvaccinated people, to help further protect them from getting severely ill or dying due to COVID-19.

All available flu vaccines in the United States this flu season are quadrivalent (four-component) flu vaccines that are designed to protect against the four flu viruses that research indicates are most likely to spread and cause illness among people during the upcoming flu season.

There is no cost for either of these vaccines. To help us prepare for these fast-approaching dates, please read the enclosed **PFIZER-BIONTECH COVID-19 VACCINE FACT SHEET,** and then complete the **COVID-19 Vaccination Consent form** and **Informed Consent to Receive Vaccines** for the person(s) in our services. These forms must be **returned by October 11, 2021.** For your convenience, we have enclosed a return envelope.

If you have questions, we have resources and information available on our website or you may contact Pam Hackathorn, P.I. RN at 641-275-3394.

Sincerely,

Sandy Ham
President and CEO
Progress Industries

***Individuals in services will need to bring their COVID vaccination card with them to the vaccination clinic.**

VACCINE INFORMATION FACT SHEET FOR RECIPIENTS AND CAREGIVERS ABOUT COMIRNATY (COVID-19 VACCINE, mRNA) AND PFIZER-BIONTECH COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19)

You are being offered either COMIRNATY (COVID-19 Vaccine, mRNA) or the Pfizer-BioNTech COVID-19 Vaccine to prevent Coronavirus Disease 2019 (COVID-19) caused by SARS-CoV-2.

This Vaccine Information Fact Sheet for Recipients and Caregivers comprises the Fact Sheet for the authorized Pfizer-BioNTech COVID-19 Vaccine and also includes information about the FDA-licensed vaccine, COMIRNATY (COVID-19 Vaccine, mRNA).

The FDA-approved COMIRNATY (COVID-19 Vaccine, mRNA) and the FDA-authorized Pfizer-BioNTech COVID-19 Vaccine under Emergency Use Authorization (EUA) have the same formulation and can be used interchangeably to provide the COVID-19 vaccination series.[1]

COMIRNATY (COVID-19 Vaccine, mRNA) is an FDA-approved COVID-19 vaccine made by Pfizer for BioNTech.

- **It is approved as a 2-dose series for prevention of COVID-19 in individuals 16 years of age and older.**
- **It is also authorized under EUA to be administered to:**
  - **prevent COVID-19 in individuals 12 through 15 years, and**
  - **provide a third dose to individuals 12 years of age and older who have been determined to have certain kinds of immunocompromise.**

The Pfizer-BioNTech COVID-19 Vaccine has received EUA from FDA to:

- **prevent COVID-19 in individuals 12 years of age and older, and**
- **provide a third dose to individuals 12 years of age and older who have been determined to have certain kinds of immunocompromise.**

This Vaccine Information Fact Sheet contains information to help you understand the risks and benefits of COMIRNATY (COVID-19 Vaccine, mRNA) and the Pfizer-BioNTech COVID-19 Vaccine, which you may receive because there is currently a pandemic of COVID-19. Talk to your vaccination provider if you have questions.

COMIRNATY (COVID-19 Vaccine, mRNA) and the Pfizer-BioNTech COVID-19 Vaccine are administered as a 2-dose series, 3 weeks apart, into the muscle.

[1] The licensed vaccine has the same formulation as the EUA-authorized vaccine and the products can be used interchangeably to provide the vaccination series without presenting any safety or effectiveness concerns. The products are legally distinct with certain differences that do not impact safety or effectiveness.

Under EUA for individuals who are determined to have certain kinds of immunocompromise, a third dose may be administered at least 4 weeks after the second dose.

COMIRNATY (COVID-19 Vaccine, mRNA) and the Pfizer-BioNTech COVID-19 Vaccine may not protect everyone.

This Fact Sheet may have been updated. For the most recent Fact Sheet, please see www.cvdvaccine.com.

WHAT YOU NEED TO KNOW BEFORE YOU GET THIS VACCINE

WHAT IS COVID-19?

COVID-19 disease is caused by a coronavirus called SARS-CoV-2. You can get COVID-19 through contact with another person who has the virus. It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness leading to death. Symptoms may appear 2 to 14 days after exposure to the virus. Symptoms may include: fever or chills; 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.

WHAT IS COMIRNATY (COVID-19 VACCINE, mRNA) AND HOW IS IT RELATED TO THE PFIZER-BIONTECH COVID-19 VACCINE?

COMIRNATY (COVID-19 Vaccine, mRNA) and the Pfizer-BioNTech COVID-19 Vaccine have the same formulation and can be used interchangeably to provide the COVID-19 vaccination series.[1]

For more information on EUA, see the "**What is an Emergency Use Authorization (EUA)?**" section at the end of this Fact Sheet.

[1] The licensed vaccine has the same formulation as the EUA-authorized vaccine and the products can be used interchangeably to provide the vaccination series without presenting any safety or effectiveness concerns. The products are legally distinct with certain differences that do not impact safety or effectiveness.

WHAT SHOULD YOU MENTION TO YOUR VACCINATION PROVIDER BEFORE YOU GET THE VACCINE?

Tell the vaccination provider about all of your medical conditions, including if you:

- have any allergies
- have had myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining outside the heart)
- have a fever
- have a bleeding disorder or are on a blood thinner
- are immunocompromised or are on a medicine that affects your immune system
- are pregnant or plan to become pregnant
- are breastfeeding
- have received another COVID-19 vaccine
- have ever fainted in association with an injection

WHO SHOULD GET THE VACCINE?

FDA has approved COMIRNATY (COVID-19 Vaccine, mRNA) for use in individuals 16 years of age and older and has authorized it for emergency use in individuals 12 through 15 years.

FDA has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine in individuals 12 years of age and older.

WHO SHOULD <u>NOT</u> GET THE VACCINE?

You should not get the COMIRNATY (COVID-19 Vaccine, mRNA) or the Pfizer-BioNTech COVID-19 Vaccine if you:

- had a severe allergic reaction after a previous dose of this vaccine
- had a severe allergic reaction to any ingredient of this vaccine.

WHAT ARE THE INGREDIENTS IN COMIRNATY (COVID-19 VACCINE, mRNA) AND THE PFIZER-BIONTECH COVID-19 VACCINE?

COMIRNATY (COVID-19 Vaccine, mRNA) and the Pfizer-BioNTech COVID-19 Vaccine include the following ingredients: mRNA, lipids ((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene glycol)-2000]-N,N-ditetradecylacetamide, 1,2-Distearoyl-sn-glycero-3-phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose.

HOW IS THE VACCINE GIVEN?

COMIRNATY (COVID-19 Vaccine, mRNA) and the Pfizer-BioNTech COVID-19 Vaccine will be given to you as an injection into the muscle.

The vaccination series is 2 doses given 3 weeks apart.

If you receive one dose of the vaccine, you should receive a second dose of the vaccine 3 weeks later to complete the vaccination series.

HAVE COMIRNATY (COVID-19 VACCINE, mRNA) AND THE PFIZER-BIONTECH COVID-19 VACCINE BEEN USED BEFORE?

In clinical trials, approximately 23,000 individuals 12 years of age and older have received at least 1 dose of the Pfizer-BioNTech COVID-19 Vaccine. Data from these clinical trials supported the Emergency Use Authorization of the Pfizer-BioNTech COVID-19 Vaccine and the approval of COMIRNATY (COVID-19 Vaccine, mRNA). Millions of individuals have received the Pfizer-BioNTech COVID-19 Vaccine under EUA since December 11, 2020.

WHAT ARE THE BENEFITS OF COMIRNATY (COVID-19 VACCINE, mRNA) AND THE PFIZER-BIONTECH COVID-19 VACCINE?

The vaccine has been shown to prevent COVID-19 following 2 doses given 3 weeks apart. The duration of protection against COVID-19 is currently unknown.

WHAT ARE THE RISKS OF COMIRNATY (COVID-19 VACCINE, mRNA) AND THE PFIZER-BIONTECH COVID-19 VACCINE?

There is a remote chance that the vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the vaccine. For this reason, your vaccination provider may ask you to stay at the place where you received your vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include:

- Difficulty breathing
- Swelling of your face and throat
- A fast heartbeat
- A bad rash all over your body
- Dizziness and weakness

Myocarditis (inflammation of the heart muscle) and pericarditis (inflammation of the lining outside the heart) have occurred in some people who have received COMIRNATY (COVID-19 Vaccine, mRNA) or the Pfizer-BioNTech COVID-19 Vaccine. In most of these people, symptoms began within a few days following receipt of the second dose of vaccine. The chance of having this occur is very low. You should seek medical attention right away if you have any of the following symptoms after receiving the vaccine:

- Chest pain
- Shortness of breath
- Feelings of having a fast-beating, fluttering, or pounding heart

Side effects that have been reported with COMIRNATY (COVID-19 Vaccine, mRNA) or the Pfizer-BioNTech COVID-19 Vaccine include:

- severe allergic reactions
- non-severe allergic reactions such as rash, itching, hives, or swelling of the face
- myocarditis (inflammation of the heart muscle)
- pericarditis (inflammation of the lining outside the heart)
- injection site pain
- tiredness
- headache

- muscle pain
- chills
- joint pain
- fever
- injection site swelling
- injection site redness
- nausea
- feeling unwell
- swollen lymph nodes (lymphadenopathy)
- diarrhea
- vomiting
- arm pain

These may not be all the possible side effects of the vaccine. Serious and unexpected side effects may occur. The possible side effects of the vaccine are still being studied in clinical trials.

WHAT SHOULD I DO ABOUT SIDE EFFECTS?
If you experience a severe allergic reaction, call 9-1-1, or go to the nearest hospital.

Call the vaccination provider or your healthcare provider if you have any side effects that bother you or do not go away.

Report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS). The VAERS toll-free number is 1-800-822-7967 or report online to https://vaers.hhs.gov/reportevent.html. Please include either "COMIRNATY (COVID-19 Vaccine, mRNA)" or "Pfizer-BioNTech COVID-19 Vaccine EUA", as appropriate, in the first line of box #18 of the report form.

In addition, you can report side effects to Pfizer Inc. at the contact information provided below.

Website	Fax number	Telephone number
www.pfizersafetyreporting.com	1-866-635-8337	1-800-438-1985

You may also be given an option to enroll in v-safe. V-safe is a new voluntary smartphone-based tool that uses text messaging and web surveys to check in with people who have been vaccinated to identify potential side effects after COVID-19 vaccination. V-safe asks questions that help CDC monitor the safety of COVID-19 vaccines. V-safe also provides second-dose reminders if needed and live telephone follow-up by CDC if participants report a significant health impact following COVID-19 vaccination. For more information on how to sign up, visit: www.cdc.gov/vsafe.

WHAT IF I DECIDE NOT TO GET COMIRNATY (COVID-19 VACCINE, mRNA) OR THE PFIZER-BIONTECH COVID-19 VACCINE?
Under the EUA, it is your choice to receive or not receive the vaccine. Should you decide not to receive it, it will not change your standard medical care.

ARE OTHER CHOICES AVAILABLE FOR PREVENTING COVID-19 BESIDES COMIRNATY (COVID-19 VACCINE, mRNA) OR PFIZER-BIONTECH COVID-19 VACCINE?
Other vaccines to prevent COVID-19 may be available under Emergency Use Authorization.

CAN I RECEIVE THE COMIRNATY (COVID-19 VACCINE, mRNA) OR PFIZER-BIONTECH COVID-19 VACCINE AT THE SAME TIME AS OTHER VACCINES?
Data have not yet been submitted to FDA on administration of COMIRNATY (COVID-19 Vaccine, mRNA) or the Pfizer-BioNTech COVID-19 Vaccine at the same time with other vaccines. If you are considering receiving COMIRNATY (COVID-19 Vaccine, mRNA) or the Pfizer-BioNTech COVID-19 Vaccine with other vaccines, discuss your options with your healthcare provider.

WHAT IF I AM IMMUNOCOMPROMISED?
If you are immunocompromised, you may receive a third dose of the vaccine. The third dose may still not provide full immunity to COVID-19 in people who are immunocompromised, and you should continue to maintain physical precautions to help prevent COVID-19. In addition, your close contacts should be vaccinated as appropriate.

WHAT IF I AM PREGNANT OR BREASTFEEDING?
If you are pregnant or breastfeeding, discuss your options with your healthcare provider.

WILL COMIRNATY (COVID-19 VACCINE, mRNA) OR THE PFIZER-BIONTECH COVID-19 VACCINE GIVE ME COVID-19?
No. The vaccine does not contain SARS-CoV-2 and cannot give you COVID-19.

KEEP YOUR VACCINATION CARD
When you get your first dose, you will get a vaccination card to show you when to return for your second dose or if you have certain kinds of immunocompromise, your third dose of COMIRNATY (COVID-19 Vaccine, mRNA) or Pfizer-BioNTech COVID-19 Vaccine. Remember to bring your card when you return.

ADDITIONAL INFORMATION

If you have questions, visit the website or call the telephone number provided below.

To access the most recent Fact Sheets, please scan the QR code provided below.

Global website	Telephone number
www.cvdvaccine.com	1-877-829-2619 (1-877-VAX-CO19)

HOW CAN I LEARN MORE?

- Ask the vaccination provider.
- Visit CDC at https://www.cdc.gov/coronavirus/2019-ncov/index.html.
- Visit FDA at https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization.
- Contact your local or state public health department.

WHERE WILL MY VACCINATION INFORMATION BE RECORDED?

The vaccination provider may include your vaccination information in your state/local jurisdiction's Immunization Information System (IIS) or other designated system. This will ensure that you receive the same vaccine when you return for the second dose. For more information about IISs visit: https://www.cdc.gov/vaccines/programs/iis/about.html.

CAN I BE CHARGED AN ADMINISTRATION FEE FOR RECEIPT OF THE COVID-19 VACCINE?

No. At this time, the provider cannot charge you for a vaccine dose and you cannot be charged an out-of-pocket vaccine administration fee or any other fee if only receiving a COVID-19 vaccination. However, vaccination providers may seek appropriate reimbursement from a program or plan that covers COVID-19 vaccine administration fees for the vaccine recipient (private insurance, Medicare, Medicaid, Health Resources & Services Administration [HRSA] COVID-19 Uninsured Program for non-insured recipients).

WHERE CAN I REPORT CASES OF SUSPECTED FRAUD?

Individuals becoming aware of any potential violations of the CDC COVID-19 Vaccination Program requirements are encouraged to report them to the Office of the Inspector General, U.S. Department of Health and Human Services, at 1-800-HHS-TIPS or https://TIPS.HHS.GOV.

WHAT IS THE COUNTERMEASURES INJURY COMPENSATION PROGRAM?

The Countermeasures Injury Compensation Program (CICP) is a federal program that may help pay for costs of medical care and other specific expenses of certain people who have been seriously injured by certain medicines or vaccines, including this vaccine. Generally, a claim must be submitted to the CICP within one (1) year from the

date of receiving the vaccine. To learn more about this program, visit www.hrsa.gov/cicp/ or call 1-855-266-2427.

WHAT IS AN EMERGENCY USE AUTHORIZATION (EUA)?
An Emergency Use Authorization (EUA) is a mechanism to facilitate the availability and use of medical products, including vaccines, during public health emergencies, such as the current COVID-19 pandemic. An EUA is supported by a Secretary of Health and Human Services (HHS) declaration that circumstances exist to justify the emergency use of drugs and biological products during the COVID-19 pandemic.

The FDA may issue an EUA when certain criteria are met, which includes that there are no adequate, approved, available alternatives. In addition, the FDA decision is based on the totality of scientific evidence available showing that the product may be effective to prevent COVID-19 during the COVID-19 pandemic and that the known and potential benefits of the product outweigh the known and potential risks of the product. All of these criteria must be met to allow for the product to be used in the treatment of patients during the COVID-19 pandemic.

This EUA for the Pfizer-BioNTech COVID-19 Vaccine and COMIRNATY will end when the Secretary of HHS determines that the circumstances justifying the EUA no longer exist or when there is a change in the approval status of the product such that an EUA is no longer needed.

Pfizer

Manufactured by
Pfizer Inc., New York, NY 10017

BIONTECH

Manufactured for
BioNTech Manufacturing GmbH
An der Goldgrube 12
55131 Mainz, Germany

LAB-1451-7.2

Revised: 23 August 2021

Scan to capture that this Fact Sheet was provided to vaccine recipient for the electronic medical records/immunization information systems.

Barcode Date: 08/2021

COVID-19 Vaccine Consent and Administration Record

PATIENT INFORMATION (Person Served Information)

Name: _____ **Date of Birth:** ___/___/___ **Gender:** _____ **Phone:** _____

Home Address: _____ **City, State:** _____ **Zip:** _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown **Email Address** _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African-American

☐ White ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other Race

Hy-Vee Pharmacy will send vaccination information from this visit to your primary care provider using the contact information provided below. **(OPTIONAL)**

Primary Care Provider (PCP) Name: _____ **PCP Contact Information:** _____

If someone else manages healthcare decisions on the patient's behalf, please provide the following:

Legal Decision-Maker Name: _____ **Relationship:** _____ **Phone:** _____

INSURANCE INFORMATION – Please fill in all that apply

- **Prescription Insurance** ☐ Check box if patient is the primary card holder

Pharmacy Insurance Provider: _____ **Member ID #:** _____ **Rx Group #:** _____

RX BIN: _____ **RX PCN:** _____

- **Medicare Beneficiaries** (the COVID Vaccine will be billed at Part B through your Medicare provider)

Is the patient age 65 or older or is the patient Medicare Eligible? ☐ Yes ☐ No Medicare Number (MBI): _____

- **Medical Insurance** ☐ Check box if patient is the primary card holder

Medical Insurance Provider: _____ **Member ID #:** _____ **Payer ID:** _____

- **Uninsured – COVID-19 VACCINE ONLY** Required: Driver's license or Social security # _____

If you are uninsured, please read the following statement and check the box for acknowledgement:

☐ I do not have medical insurance, Medicare, Medicaid, or any government-funded health benefit plan or any commercial plan. I understand that I must answer this question truthfully in order to have the cost of my vaccination covered by the federal COVID-19 Uninsured Program. I understand that if I fail to disclose any active insurance I have, I may be charged in full for the COVID-19 vaccine.

SCREENING QUESTIONS FOR COVID-19 VACCINE

The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider.

		Yes	No	Don't Know
1.	Are you sick today?	☐	☐	☐
2.	Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing. If Yes, the vaccine is contraindicated)			
	• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
	• Polysorbate	☐	☐	☐
	• A previous dose of COVID-19 vaccine	☐	☐	☐
3.	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? (This would include food, pet, environmental, or oral medication allergies. Yes = Provider to observe patient for 30 min)	☐	☐	☐
4.	Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing. Yes= Provider observe pt for 30 min)	☐	☐	☐

5.	Do you have a weakened immune system caused by something such as cancer or HIV infection or do you take immunosuppressive drugs or therapies?	☐	☐	☐
6.	Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
7.	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
8.	Have you received any vaccine in the last 14 days?	☐	☐	☐
9.	Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
10.	In the past 14 days, have you tested positive for COVID-19 or are you currently waiting on the results of a COVID-19 test?	☐	☐	☐
11.	Within the past 14 days, have you been in close physical contact with anyone who is known to have laboratory-confirmed COVID-19?	☐	☐	☐
12.	Within the past 14 days, have you been in close physical contact with anyone who has any symptoms consistent with COVID-19?	☐	☐	☐
13.	Have you experienced any of the following symptoms in the past 48 hours: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea?	☐	☐	☐
14.	Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	☐	☐	☐
15.	Have you ever received a dose of a COVID-19 vaccine?	☐	☐	☐
	• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Another product_____Date of 1st dose:_____Date of 2nd Dose: _____			
16.	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
17.	Are you eligible to receive a third dose of COVID-19 vaccine based upon current ACIP guidelines regarding immunocompromised individuals?	☐	☐	☐

PATIENT CONSENT

CONSENT FOR VACCINE SERVICES. I have read, or have had read to me, the Vaccine Information Statement (VIS) or Emergency Use Authorization (EUA) Fact Sheet for Recipients and Caregivers provided for the vaccine(s) to be administered. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and voluntarily assume full responsibility for any reactions that may result. I give my consent to the staff of Hy-Vee Pharmacy to administer the vaccine(s) marked above. I have been advised to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I hereby release Hy-Vee, its officers, employees and agents from any and all liability, whether known or unknown, that in any way arise from this vaccination on behalf of myself, my heirs and personal representatives.

PAYMENT AUTHORIZATION. I hereby authorize Hy-Vee Pharmacy to request payment and release all information needed to act on this request. I certify that the information given by me in applying for payment under Medicare or Medicaid is correct. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS. I acknowledge that Hy-Vee Pharmacy may be required to or may voluntarily disclose my health information concerning the vaccine(s) to my primary care physician (if provided), my insurance plan, and/or local, state, or federal registries/health agencies, if applicable. I acknowledge that, depending on my state law, I may object to the disclosure of my vaccination information to the state registry. I understand that my health information will be used and disclosed as set forth in the Hy-Vee Pharmacy Notice of Privacy Practices, which is available online or upon request.

By signing below, I certify that I am the patient or the patient's guardian/representative authorized to provide consent on their behalf, and that I have read, understand and agree to all the statements on this form.

_____ _____

Patient or Guardian Signature **Date**

FOR PHARMACY USE ONLY

Vaccine	Admin Date	Dose (mL)	Vaccine			Route (IM/SQ/ NAS)	Site (RA/LA, RT/LT)	VIS or EUA Fact Sheet:	
			Lot #	Exp Date	Manufacturer			Pub Date	Date Given

Administering Immunizer Name & Title: _____ **Administering Immunizer Signature:** _____ _____

Pharmacy Address: **City, State, Zip:** **Store #:**

If applicable,
Supervising Pharmacist Name: _____ **Supervising Pharmacist Signature:** _____

Adverse Reaction (attach VAERS form) Notification to Primary Provider: _____ **(date)**

Informed Consent to Receive Vaccines

Name: _____ **Date of Birth**_____ **Male/Female**
Person Served Person Served

Street: _____ **City**_____ **Zip** _____
Person Served

Phone: _____ **Primary Care Provider (optional):** _____
Person Served

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, foods or any vaccine? (i.e. gelatin, eggs, latex, etc.)	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (i.e., diabetes), anemia, or other blood disorder?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, history of lymph node removal (i.e. mastectomy) or any immune system problem?	☐	☐	☐
6. 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?	☐	☐	☐
7. Have you had a seizure or a brain or other nervous system problem? (i.e. Guillain-Barre Syndrome, encephalopathy)	☐	☐	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune globulin or an antiviral drug?	☐	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
11. Are you currently taking anticoagulant or antiplatelet medications? (Coumadin, warfarin, aspirin, Plavix, Lovenox, etc.)	☐	☐	☐
12. Are you current on all your vaccinations? (Pneumonia, Shingles, TdaP, etc.)	☐	☐	☐
13. Where would you like the vaccine administered? (please choose one location) Adults: Left Arm Right Arm Children: Left Arm Right Arm Left Thigh Right Thigh			

I have read, or have had read to me, the Vaccine Information Statement (VIS) indicated below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s) marked above. I authorize the information to be forwarded to my primary care physician, authorizing physician and state registry, if applicable. I agree to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I hereby release Hy-Vee, its officers, employees and agents from any and all liability that might arise from this vaccination on behalf of myself, my heirs and personal representatives.

_____ _____
Patient or Guardian Signature **Date**

Authorized Pharmacist (And intern if applicable) (Administers vaccine and reviews questionnaire)	Admin Date/ VIS given to patient date	Vaccine	Vaccine Lot	#Exp Date	Manufacturer	VIS Date	Dose (mL)

Admin Site: Right---Left –Arm---Thigh---Nasal—SQ—IM Adverse Reaction (attach VAERS form) Notification to Primary Provider _____ (date)