Discount Drug Mart Vaccine Administration and Consent Form
Medina County Board of Developmental Disabilities

VACCINE RECIPIENT INFORMATION

Patient Name:_____ **Date of Birth:**_____/_____/_____ **Age:**_____

Address:_____ **County:**_____

City:_____ **State:**_____ **Zip Code:**_____

Phone Number:_____ **SSN/DL#:**_____

Parent/Guardian Name:_____ **Parent/Guardian Phone Number:**_____

Allergies:_____ **Chronic Conditions:**_____

Primary Care Physician:_____ **PCP Phone Number:**_____

Race: ☐**White** ☐**Black/African American** ☐**Hispanic** ☐**Asian** ☐**American Indian/Alaskan Native**
☐**Native Hawaiian/Other Pacific Islander** ☐**Other:**_____ ☐**Prefer Not to Answer**

Ethnicity: Are you of Hispanic, Latino, or Spanish origin?
☐**Yes-Please specify:**_____ ☐**No-Not of Hispanic, Latino, or Spanish origin**

Gender:_____

VACCINES REQUESTED (circle all that apply):

COVID Influenza (Flu) Hepatitis A Hepatitis B Hepatitis A & B Pneumonia RSV Tdap Zoster (Shingles)

SCREENING QUESTIONNAIRE FOR IMMUNIZATIONS	YES	NO
1. Are you sick today?		
2. Do you have any allergies to medication, food, latex, yeast, neomycin, gelatin, or any vaccine component? Please list above.		
3. Have you ever had a serious reaction after receiving a vaccine?		
4. Have you ever received a COVID, Hepatitis, MMR, Meningitis, Pneumonia, or Zoster (Shingles) vaccine? If Yes, which vaccine?		
5. Have you had any vaccines administered to you in the past 2 OR 4 weeks?		
6. Do you have asplenia or abnormal spleen function?		
7. Do you have a history of Guillain-Barre syndrome (GBS)?		
8. Do you have a history of thrombocytopenia or thrombocytopenic purpura?		
9. Are you currently taking any anti-viral medication or blood thinners?		
10. Do you, anyone who lives with you, or anyone you take care of: Take cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatments? OR Have cancer, leukemia, AIDS, or any other immune system problems?		
11. During the past year, have you received a transfusion of blood or plasma or been given immune globulin?		
12. Are you pregnant, planning on becoming pregnant in the next month, or breast-feeding?		

For **MEDICARE** or INSURANCE recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to Discount Drug Mart. If a claim rejects, I will be charged cash. For patient reimbursement, the patient must submit their Cash Receipt to their major medical benefits provider. I have read or have had explained to me the information in the Vaccine Information Statement about the vaccine(s) I circled above. I have had a chance to ask questions that were answered to my satisfaction. I attest that I meet the requirements to receive the selected vaccine(s) to be administered I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or the person named below for whom I am authorized to make this request. I agree to receive treatment for any adverse event that may occur after receiving the vaccine(s) while on site. In the event of an accidental post vaccination needle stick to the vaccine administrator, I agree to be contacted for follow up lab work. I have received the VIS Form and the Discount Drug Mart NOPP.

Physician on Record: Julia Bruner, MD MS 2500 MetroHealth Drive Cleveland, OH 44109

SIGNATURE OF PATIENT (IF PATIENT IS 18 YEARS OF AGE OR OLDER): _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN AUTHORIZING VACCINATION
(IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE): _____

DATE:_____

BILLING INFORMATION

CIRCLE ONE: EMPLOYER INVOICE CASH PRESCRIPTION PLAN MAJOR MEDICAL

MEDICARE B MEDICARE D EMPLOYEE INVOICE

PLAN NAME:_____

MEDICAL ID:_____ **MEDICAL GROUP:**_____

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

RX ID:_____ **RX GROUP:**_____

RELATIONSHIP (CIRCLE ONE): HOLDER SPOUSE CHILD DEPENDENT

*****FOR PHARMACY USE ONLY*****

VACCINES ADMINISTERED							
Vaccine Name	**Manufacturer**	**Dose Quantity**	**Dose Number**	**Route**	**Site**	**Lot**	**Expiration**

Signature and Title of Vaccine Administrator:_____

Printed Name:_____ Date:_____

****Following billing priority-CLINIC SPECIFIC****

131:

- ***Aetna Commercial ONLY***-Flu
- ***Aultcare SERS & STRS-***Flu, Pneumonia, Shingrix
- ***Cigna***-Flu, Pneumonia
- ***MMO (NO MEDICARE SUPPLEMENT)***-Flu, Pneumonia, Shingrix
- ***PrimeTime***-Flu, Pneumonia
- ***Summa***-Flu, Pneumonia

431: ***MMO***-COVID
499: ***MMO***-Flu Clinic (FLU ONLY)
2083: ***Aetna B***-Flu, Pneumonia
3130: ***Medicare B***-Flu, Pneumonia
3188: ***Cigna***-All Vaccines
4130: ***Medicare B***-COVID
All others: Rx Benefit or Cash

ICD-10 CODE: Z23

LIST RX NUMBER(S) AND VACCINE NAME(S) HERE: