Jerry's Drug and Surgical
455 Broadway Bayonne, NJ 07002 Phone: 201-339-1992
Vaccine Administration Record (VAR) & Consent for Vaccine and NJIIS Participation

____
Last Name (print) First Name Date of Birth Age Country of Birth

____
Home address City County State Zip Phone

1	Are you feeling sick today?	Yes	No
2	Have you ever received a Covid-19 Vaccine? Which one?___________________		
3	Have you ever had an allergic reaction to Polysorbate, any vaccine, any vaccine component or injection?		
4	Have you ever had a severe allergic reaction (eg. Anaphylaxis) to anything?(includes food, pets etc…		
5	Have you received any vaccine in the last 14 days?		
6	Have you tested positive for Covid-19 or had a physician say you have Covid-19 within the last 14 days?		
7	Have you received passive antibody therapy 9monoclonal antibodies or convalescent serum) as treatment for Covid-19?		
8	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?		
9	Do you have a bleeding disorder or are you taking a blood thinner?		
10	Are you pregnant or breastfeeding?		
11	Do you have dermal fillers?		
12	In which arm would like the injection? Circle one	Left	Rt
13	Race: circle one: Asian Black/African Am. Am.Indian/Alaskan Native White Pacific Island/Native Hawaiian Other:		
14	Ethnicity: circle one Hispanic or Latino Non-Hispanic or Latino Decline/Unknown		
15	Gender: Circle one: Male Female Non-Binary Other/Unknown		

I certify that I am: (i)if patient, I am at least 18 years of age, (ii)the legal guardian of the patient. I hereby give my consent to the pharmacist of Jerry's Drug and Surgical to administer the vaccine listed on this page. I have read or have had read to me the Vaccine Fact Sheet or Emergency Use Authorization (EUA). I understand the risks and benefits of getting this vaccine. I am responsible for: following up with my physician if I experience any side effects, remaining in the waiting area for 15 minutes, notifying the pharmacist of any side effects. If I have a history of anaphylaxis I will wait 30 minutes for observation and let the pharmacist know before the vaccination. I have had the opportunity to ask any questions and have had all my questions answered. I understand the benefits and risks of the vaccine. I have been offered or given a copy of the company's privacy practices. I consent to share my medical information to the NJIIS, my physician, local and state health departments.

Insurance: RxBIN:________ PCN:______________ Group#_______________ ID#_________________________

Medicare or other Insurance: Carrier:________________________ ID#________________________(Photo copy given)

If no Insurance: Need Social Security #__________________ OR Driver's License (or State Id)#:______________________

Signature of Patient or Parent/Guardian: ____ Date: ______________

Vaccine Name	Manuf.	NDC	Mnftr Lot #	Exp. Date	Dose	Route	Site (circle)	EUA Pub. Date
Covid-19	Janssen (J&J)	59676-0580-05			0.5ml	IM	L / R Deltoid	02/27/2021

Name of Administrator: _______________________ Admin Date: __________
RPh Signature, Indicates EUA provided, counseling offered, patient eligibility verified: ____________________________
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