Sayreville Pharmacy INC

89 Main Street

Sayreville, NJ 08872

732-254-5858

Insurance plan and/or Medicare Card along with State ID required at the time of COVID Immunization Administration OR OTHER VACCINE(s)

Your Name Last_____ First _____

Date of Birth _____ SSN _____

Medicare Number for over age of 65 _____

Prescription Plan Information _____

BIN# _____

PCN# _____

RX Group _____

ID # _____

Relationship circle one Primary Spouse Child

If not Primary, Please provide primary Insured's name:_____

_____ only if you are uninsured * when pharmacy has contract will be available

I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid or other third party payer as needed and request payment of authorized benefits to be made on my behalf to Sayreville Pharmacy.

- I acknowledge that if my insurance does not cover the cost of administering the vaccine at the pharmacy then payment must be made at the time of the administration of the vaccine
- I acknowledge that my vaccination record may be shared with federal or state or city agencies for registry for reporting
- I acknowledge that receipt of Sayreville Pharmacy's Notice of privacy Practices for Protected Health Information if requested.
- I acknowledge that the pharmacist recommends and may require you to remain in the pharmacy for 15 minutes after the vaccine administration.
- I acknowledge that immunization or vaccine does not substitute for an annual check up with primary physician
- I certify my receipt of the services covered by this claim. I request that payment be made on my behalf and authorize the holder to release medical information about me to any party involved in payment or their agents
- I have read, or have had read to me the Vaccination Information Sheet(VIS) regarding vaccine if not obtained from CDC or pharmacy. I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine(S). I consent to, or give consent for the administration of the vaccine(S). I fully release the discharge Sayreville Pharmacy INC

Patient Name:_____Date of Birth _____Age_____Phone#_____

Address:_____City_____State_____Zip_____

Email Address:_____GENDER M OR F WHICH VACCINE RECEIVED_____

ETHNICITY: HISPANIC OR LATIN(1) NOT HISPANIC OR LATINO(2) UNKNOWN

RACE: AMERICAN INDAIN/ALASKA NATIVE ASIAN

MEDICAL CONDITIONS:_____

PRIMARY CARE PHYSICIAN (PCP)_____ Dr Phone _____

I authorized the pharmacist to send copies of my vaccine documents to my primary if requested

The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask pharmacist to explain	YES	NO	DON'T KNOW
ARE YOU SICK TODAY ?			
DO YOU HAVE A LONG TERM HEALTH PROBLEM WITH HEART DISEASE, KIDNEY, DISEASE OR METABOLIC DISORDER (E.G DIABETER, ANEMIA OR OTHER BLOOD DISORDERS?			
DO YOU HAVE A LONG TERM HEALTH PROBLEM WITH LUNG DISEASE OR ASTHMA? DO YOU SMOKE?			
DO YOU HAVE ALLERGIES TO MEDICATIONS FOOD ESPECIALLY EGGS , LATEX OR ANY VACCINE COMPONENT (E.G NEOMYCIN, FORMALDEHYDE,GENTAMICIN, THIMEROSAL, BOVINE PROTEIN , PHENOL,POLYMYXIN, GELATIN, BAKER'S YEAST OR YEAST			
Have you received any Vaccinations in the past 4 weeks			
Have you had SERIOUS reaction(S) to after receiving vaccination?			
Do you have a neurological disorder such as seizures or other disorders that affect the brain or have had a disorder that resulted from vaccine (Guillaini-Barre Syndrome)			
Do you have cancer, leukemia, AIDS, or any other immune system problems? May have to refer to doctor if prefers or you are allowed to get vaccinated?			
Do you take prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?			
During the past year, have you received a transfusion of blood or blood products including antibodies?			
Are you a parent, care giver, family member			
FOR WOMEN: ARE YOU PREGNANT OR COULD YOU BECOME PREGNANT IN NEXT 3 MONTHS			
DID YOU BRING YOU IMMUNIZATION CARD WITH YOU?			
Are you currently enrolled in one of our medication adherence programs at Sayreville pharmacy (by text , email or phone?			
Have you had the following Vaccine(S) and when			
• Pneumococcal Vaccine if taken recently or date take _____			
• Shingles Vaccine Recent Date(S) date _____			
• Whooping cough (Tdap)			

Corporation or personally, its affiliates, officers, directors, and employees from any liability for illness, injury , loss, or side effects or damage may result there from.

Patient signature or legal guardian Signature:_____-

Legal guardian Print full NAME:_____

PHARMACY USE ONLY

MODERNA

INFLUENZA INJECTABLE

HEPATITIS B

ZOSTAVAX

SHINGRIX

TDAP

HEPATITIS A & B

OTHER

LOCATION: SAYREVILLE PHARMACY INC

89 MAIN STREET

SAYREVILLE, NJ 08872

Signature of the pharmacist who administered Vaccine(S) _____

Date: _____

Lot # _____

Exp _____

Site of injection circle one LEFT ARM / RIGHT ARM