

## **Vaccination Screening & Consent**

\*\*Eligible for use with live vaccines such as MMR, Varicella, Zostavax, FluMist, or Oral Typhoid\*\*

Address: City: State: Zip: Allergies: Insurance BIN: PCN: Group: ID: PCN: Fax: ID: ID: PCN: PCN: Fax: ID: PCN:	Name:						DoB:			Phone:					
Allergies:   Insurance Baw.   Primary Care Provider:   Phone:   Fax:															
Primary Care Provider:  Phone: Fax: Plon NOT have a primary care provider or am unable to provide their contact information  Fax: Po Not Provider:  I Are you sick today? Have you had amy COVID-19 symptoms in the past 14 days including: Ough Prever > 100.4°F Dreath Preventions															
Cough															
Screening Questions															
1. Are you sick today?   2. Have you had any COVID-19 symptoms in the past 14 days including:															
2. Have you had any COVID-19 symptoms in the past 14 days including:  **Cough **Output **Outp	Screening	Qu			iestion is no	t ciear, piea	se ask the ph	arm	acist to ex	piain it.		Yes	No	Know	
Cough		1.			10	. :	. 4.4	al:							
* Muscle or body aches * Chills * New loss of taste or smell * Fatigue * Leadache * Diarrhea * New loss of taste or smell * Street * New loss of taste or smell * Stague * Nausea or vomiting * (circle all that apply) * (COVID-19) infection within the past 14 days? * **STOP: If you answered vest to any of the above questions, speak with the pharmacist before completing this form** Do you Smoke? * Do you have Asthma, Diabetes, or Heart Disease? * Do you have Asthma, Diabetes, or Heart Disease? * Do you have Asthma, Diabetes, or Heart Disease? * Have you ever had a Pheumonia vaccine? If so, When? * Have you ever had a Shingles vaccine? If so, When? * Have you ever had a Shingles vaccine? If so, When? * Neomycin, Gentamicin, Latex! If Yes, please list: Neomycin, Gentamicin, Latex if Yes, please list: Neomycin, Gentamicin, Latex, If Yes, please list: Neomycin, Sentamicin, Latex, If Yes, pl		۷.	•												
Screening    - Sore throat   - New loss of taste or smell   - Congestion or runny nose   - Nause or vomiting   (circle all that apply)  - Nause or vomiting   - Nause or vomiting   (circle all that apply)  - Nause or vomiting   - Nause or vomiti				body aches			•			ctca siloi	111033 01				
* Nausea or vomiting (circle all that apply)  3. Have you had, or have you been in contact with anyone with, confirmed or suspected Coronavirus (COVID-19) infection within the past 14 days?  **STOP: If you answered yes to any of the above questions, speak with the pharmacist before completing this form**  4. Do you Smoke?  4. Do you have Asthma, Diabetes, or Heart Disease?  5. Do you have Asthma, Diabetes, or Heart Disease?  6. Have you ever had a Pheumonia vaccine? If so, When?  7. Have you ever had a Shingles vaccine? If so, When?  8. When was your most recent Tetanus shot?  9. Do you have a serious allergy to any vaccine component? (Examples: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin, Latex): If Yes, please list:  9. Do you have a serious reaction or fainted after receiving any vaccination?  11. Do you have a seizure or brain disorder or other nervous system problem?  12. Are you pregnant, or are you considering becoming pregnant in the next month?  13. Have you ever had a serious reaction or fainted after receiving any vaccination?  14. Do you have a seizure or brain disorder or other nervous system problem?  15. Do you have a parent, brother, or sister with an immune system problem?  16. In the past 3 months, have you taken medications that affect your immune system problem?  17. During the past year, have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin or an antiviral drug?  18. Lacknowledge that Lunderstand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. Lunderstand that I am giving Save Mart/Lucky your anion or an antiviral drug?  18. Lacknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. Longtime that the vaccination is all divisions has answered to my satisfaction all of my questions about the va						-	aste or smell								
* Diarrhea   Circle all that apply	Screening								•	or vomit	ing				
**STOP: If you answered yes to any of the above questions, speak with the pharmacist before completing this form**  4. Do you Smoke?  5. Do you have Asthma, Diabetes, or Heart Disease?  6. Have you ever had a Pneumonia vaccine? If so, When?  7. Have you ever had a Shingles vaccine? If so, When?  8. When was your most recent Tetanus shot?  9. Do you have a serious allergy to any vaccine component? (Examples: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin, Latex) If Yes, please list:  10. Have you ever had a serious reaction or fainted after receiving any vaccination?  11. Do you have a serious allergy to any vaccine component? (Examples: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin, Latex) If Yes, please list:  14. Do you have a seizure or brain disorder or other nervous system problem?  15. Have you received any other vaccines in the past 4 weeks? If Yes, please list:  14. Do you have a parent, brother, or sister with an immune system problem?  15. Do you have any other vaccines in the past 4 weeks? If Yes, please list:  16. Do you have a parent, brother, or sister with an immune system problem?  17. During the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?  18. Live Juring the past year, have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin or an antiviral drug?  19. During the past year, have you received a transfusion or blood or blood products, or been given medicine called immune (gamma) globulin or an antiviral drug?  19. During the past year, have you received a transfusion or blood or blood products, or been given medicine called immune (gamma) globulin or an antiviral drug?  19. During the past year, have you received a transfusion or blood or blood products, or been given medicine called immune (gamma) globulin or on antiviral drug?  10. Du			<ul> <li>Diarrhea</li> </ul>			Ü	,								
**STOP: If you answered yes to any of the above questions, speak with the pharmacist before completing this form**  4. Do you Smoke?  4. Do you Smoke?  5. Do you have Asthma, Diabetes, or Heart Disease?  6. Have you ever had a Shingles vaccine? If so, When?  7. Have you ever had a Shingles vaccine? If so, When?  8. When was your most recent Tetanus shot?  9. Do you have a serious allergy to any vaccine component? (Examples: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin, Latex) If Yes, please list:  10. Have you ever had a serious reaction or fainted after receiving any vaccination?  11. Do you have a serious reaction or fainted after receiving any vaccination?  12. Are you pregnant, or are you considering becoming pregnant in the next month?  13. Have you received any other vaccines in the past 4 weeks? If Yes, please list:  14. Do you have a serious, reaction or sister with an immune system problem?  15. Do you have a parent, brother, or sister with an immune system problem?  16. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?  17. During the past year, have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin or an antiviral drug?  1 acknowledge that I understand the benefits and risks of the requested vaccination psocedure, Irequest and consent that the vaccination is all divisions has answered to my satisfaction all of my questions about the vaccine and the vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Save Mart/Lucky Evertains and consent that the vaccination is all divisions has answered to my satisfaction all of my questions about the vaccine and the vaccination on begon operations in all divisions has answered to my satisfaction all of my questions about th		3.	Have you had	d, or have yo	u been in cor	ntact with a	nyone with, co	onfir	med or sus	pected C	oronavirus				
A. Do you have Asthma, Diabetes, or Heart Disease?		(COVID-19) infection within the past 14 days?													
5. Do you have Asthma, Diabetes, or Heart Disease? 6. Have you ever had a Pneumonia vaccine? If so, When? 7. Have you ever had a Shingles vaccine? If so, When? 8. When was your most recent Tetanus shot? 9. Do you have a serious allergy to any vaccine component? (Examples: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin, Latex) If Yes, Please list: 10. Have you ever had a serious reaction or fainted after receiving any vaccination? 11. Do you have a serious reaction or fainted after receiving any vaccination? 11. Do you have a seizure or brain disorder or other nervous system problem? 12. Are you pregnant, or are you considering becoming pregnant in the next month? 13. Have you received any other vaccines in the past 4 weeks? If Yes, please list: 14. Do you have a parent, brother, or sister with an immune system problem? 15. Do you have a parent, brother, or sister with an immune system problem? 16. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? 17. During the past year, have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin or an antiviral drug? 18. Lakenowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Save Mart/Lucky Supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccination for own more processory to my physician, Medicare, Medicare HMO, or Insurance company or immunization registry, as applicable, to enable Save Mart/Lucky to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination in a minor), my physician, Medicare, Medicare HMO, or Insurance company or imm	**STOP: If you answered yes to any of the above questions, speak with the pharmacist before completing this form**														
History 7. Have you ever had a Pneumonia vaccine? If so, When? 7. Have you ever had a Shingles vaccine? If so, When? 8. When was your most recent Tetanus shot? 9. Do you have a serious allergy to any vaccine component? (Examples: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin, Latex). If Yes, please list: 10. Have you ever had a serious reaction or fainted after receiving any vaccination? 11. Do you have a seizure or brain disorder or other nervous system problem? 12. Are you pregnant, or are you considering becoming pregnant in the next month? 13. Have you received any other vaccines in the past 4 weeks? If Yes, please list: 14. Do you have cancer, leukemia, HIV/AIDS, active shingles, or any other immune system problem? 15. Do you have a parent, brother, or sister with an immune system problem? 16. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? 17. During the past year, have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin or an antiviral drug? 18. Lacknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Save Mart/Lucky, Supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, Medicare HMO, or Insurance company or immunization registry, as applicable, to enable Save Mart/Lucky to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination is a minor, my heirs, executors and assigns hereby release Save Mart/Lucky and its divisions and affiliates and their respective officers, directors		4.													
History    History   Have you ever had a Shingles vaccine? If so, When?	Vaccine	5.													
8. When was your most recent Tetanus shot? 9. Do you have a serious allergy to any vaccine component? (Examples: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin, Latex) If Yes, please Ilst: 10. Have you ever had a serious reaction or fainted after receiving any vaccination? 11. Do you have a seizure or brain disorder or other nervous system problem? 12. Are you pregnant, or are you considering becoming pregnant in the next month? 13. Have you received any other vaccines in the past 4 weeks? If Yes, please Ilst: 14. Do you have cancer, leukemia, HIV/AIDS, active shingles, or any other immune system problem? 15. Do you have a parent, brother, or sister with an immune system problem? 16. In the past 3 months, have you taken medications that affect your immune system, such as predisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? 17. During the past year, have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin or an antiviral drug? 1 acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Save Mart/Lucky Supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccination procedure. I request and consent that the vaccination be given, as I direct Save Mart/Lucky, supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccination in procedure. I request and consent that the vaccination be given, as I direct Save Mart/Lucky, supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccination in the vaccination is provided by the manufacturer and any negligence of Save Mart/Lucky in connection	History		<b>.</b>												
9. Do you have a serious allergy to any vaccine component? (Examples: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin, Latex) If Yes, please list:  10. Have you ever had a serious reaction or fainted after receiving any vaccination?  11. Do you have a seizure or brain disorder or other nervous system problem?  Women 12. Are you pregnant, or are you considering becoming pregnant in the next month?  13. Have you received any other vaccines in the past 4 weeks? If Yes, please list:  14. Do you have a parent, brother, or sister with an immune system problem?  15. Do you have a parent, brother, or sister with an immune system problem?  16. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?  17. During the past year, have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin or an antiviral drug?  1 acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Save Mart/Lucky Supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the waccination be given, as I direct Save Mart/Lucky, either to me or to the person named above a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Save Mart/Lucky permission to release any medical or other information necessary to my physician, Medicare to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heir, executors and assigns hereby release to the vaccination. I with the vaccine and my representatives from any and all claims and their			•				ı? <u> </u>								
All Vaccines  10. Have you ever had a serious reaction or fainted after receiving any vaccination?  11. Do you have a seizure or brain disorder or other nervous system problem?  12. Are you pregnant, or are you considering becoming pregnant in the next month?  13. Have you received any other vaccines in the past 4 weeks? If Yes, please list:  14. Do you have cancer, leukemia, HIV/AIDS, active shingles, or any other immune system problem?  15. Do you have a parent, brother, or sister with an immune system problem?  16. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohr's disease, or psoriasis; or have you had radiation treatments?  17. During the past year, have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin or an antivirial drug?  1 acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Save Mart/Lucky supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Save Mart/Lucky, either to me or to the person named above a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Save Mart/Lucky permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or Insurance company or immunization registry, as applicable, to enable Save Mart/Lucky to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Save Mart/Lucky and its divisions and affiliates and their respect							.2./5								
Vaccines 50. Have you ever had a serious reaction or fainted after receiving any vaccination?  11. Do you have a seizure or brain disorder or other nervous system problem?  12. Are you pregnant, or are you considering becoming pregnant in the next month?  13. Have you received any other vaccines in the past 4 weeks? If Yes, please list:  14. Do you have cancer, leukemia, HIV/AIDS, active shingles, or any other immune system problem?  15. Do you have a parent, brother, or sister with an immune system problem?  16. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?  17. During the past year, have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin or an antiviral drug?  18. Lacknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Save Mart/Lucky Supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccination procedure. I request and consent that the vaccination be given, as I direct Save Mart/Lucky, either to me or to the person named above a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Save Mart/Lucky permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or Insurance company or immunization registry, as applicable, to enable Save Mart/Lucky to process my insurance claims with respect to the vaccination. I, for myself land for the recipient of the vaccination or release any medical or other information necessary to my physician, Medicare, Medicare, Medicare, Medicare, Medicare, Medicare, Medicare, Medicare, Medicare, Me		9.				-	onent? (Exam	pies	: Eggs, Gela	itin, Inim	ierosai,				
11. Do you have a seizure or brain disorder or other nervous system problem?   12. Are you pregnant, or are you considering becoming pregnant in the next month?   13. Have you received any other vaccines in the past 4 weeks? If Yes, please list:   14. Do you have cancer, leukemia, HIV/AIDS, active shingles, or any other immune system problem?   15. Do you have a parent, brother, or sister with an immune system problem?   16. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?   17. During the past year, have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin or an antiviral drug?   18. Despending this provided with this Consent and Release. I confirm that Save Mart/Lucky Supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Save Mart/Lucky, either to me or to the person named above a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Save Mart/Lucky permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or insurance company or immunization registry, as applicable, to enable Save Mart/Lucky to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor, my heirs, executors and assigns hereby release Save Mart/Lucky and its divisions and affiliates and their respective officers, directors, employees, agents, and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence o		10					tor receiving a	nv v	vaccination	)					
Women   12. Are you pregnant, or are you considering becoming pregnant in the next month?   13. Have you received any other vaccines in the past 4 weeks? If Yes, please list:								_							
13. Have you received any other vaccines in the past 4 weeks? If Yes, please list:  14. Do you have cancer, leukemia, HIV/AIDS, active shingles, or any other immune system problem?  15. Do you have a parent, brother, or sister with an immune system problem?  16. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?  17. During the past year, have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin or an antiviral drug?  1 acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Save Mart/Lucky Supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccine and the vaccination procerule. I request and consent that the vaccination be given, as I direct Save Mart/Lucky, either to me or to the person named above a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Save Mart/Lucky permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or Insurance company or immunization registry, as applicable, to enable Saw Mart/Lucky process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Save Mart/Lucky and its divisions and affiliates and their respective Officers, directors, employees, agents, and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Save Mart/Lucky in connection with the re										n?					
Live Vaccines Only  15. Do you have a parent, brother, or sister with an immune system problem? 16. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? 17. During the past year, have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin or an antiviral drug? 18. Lacknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Save Mart/Lucky Supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Save Mart/Lucky, either to me or to the person named above a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Save Mart/Lucky permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or Insurance company or immunization registry, as applicable, to enable Save Mart/Lucky to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Save Mart/Lucky and its divisions and affiliates and their respective officers, directors, employees, agents, and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Save Mart/Lucky and its divisions and affiliates and their respective officers, directors, employees, agents, and representatives from any and all claims arising out of or in connection with the rela	vvoinen									1;					
Live Vaccines Only  15. Do you have a parent, brother, or sister with an immune system problem? 16. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? 17. During the past year, have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin or an antiviral drug?  I acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Save Mart/Lucky Supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Save Mart/Lucky, either to me or to the person named above a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Save Mart/Lucky process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Save Mart/Lucky and its divisions and affiliates and their respective officers, directors, employees, agents, and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Save Mart/Lucky in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.  X   Vaccine  Lot # Exp Date Mfr Dosage Injection Site Time Date on VIS															
16. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?  17. During the past year, have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin or an antiviral drug?  I acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Save Mart/Lucky Supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Save Mart/Lucky, either to me or to the person named above a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Save Mart/Lucky permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or insurance company or immunization registry, as applicable, to enable Save Mart/Lucky to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Save Mart/Lucky and its divisions and affiliates and their respective officers, directors, employees, agents, and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Save Mart/Lucky in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.    Vaccine   Lot #   Exp Date   Mfr   Dosage   Injection Site   Time   Date on VIS															
prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?  17. During the past year, have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin or an antiviral drug?  I acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Save Mart/Lucky Supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Save Mart/Lucky, either to me or to the person named above a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Save Mart/Lucky permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or Insurance company or immunization registry, as applicable, to enable Save Mart/Lucky to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Save Mart/Lucky and its divisions and affiliates and their respective officers, directors, employees, agents, and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Save Mart/Lucky in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.  X  Signature of Person to Receive Vaccine / Parent or Guardian of Minor Date Print name of Parent or Guardian and Phone Number  ***********************************	Live														
Crohn's disease, or psoriasis; or have you had radiation treatments?  17. During the past year, have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin or an antiviral drug?  I acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Save Mart/Lucky Supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Save Mart/Lucky, either to me or to the person named above a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Save Mart/Lucky permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or Insurance company or immunization registry, as applicable, to enable Save Mart/Lucky to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Save Mart/Lucky and its divisions and affiliates and their respective officers, directors, employees, agents, and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Save Mart/Lucky in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.  X  Signature of Person to Receive Vaccine / Parent or Guardian of Minor  Date  Print name of Parent or Guardian and Phone Number  ***********************************	vaccines														
medicine called immune (gamma) globulin or an antiviral drug?  I acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Save Mart/Lucky Supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Save Mart/Lucky, either to me or to the person named above a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Save Mart/Lucky permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or Insurance company or immunization registry, as applicable, to enable Save Mart/Lucky to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Save Mart/Lucky and its divisions and affiliates and their respective officers, directors, employees, agents, and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Save Mart/Lucky in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.  X  Signature of Person to Receive Vaccine / Parent or Guardian of Minor Date Print name of Parent or Guardian and Phone Number  ***********************************	Uniy		Crohn's disea	ase, or psoria	sis; or have y	ou had radi	ation treatme	nts?							
I acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Save Mart/Lucky Supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Save Mart/Lucky, either to me or to the person named above a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Save Mart/Lucky permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or Insurance company or immunization registry, as applicable, to enable Save Mart/Lucky to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Save Mart/Lucky and its divisions and affiliates and their respective officers, directors, employees, agents, and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Save Mart/Lucky in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.   X  Signature of Person to Receive Vaccine / Parent or Guardian of Minor Date Print name of Parent or Guardian and Phone Number  ***********************************															
provided with this Consent and Release. I confirm that Save Mart/Lucky Supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Save Mart/Lucky, either to me or to the person named above a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Save Mart/Lucky permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or Insurance company or immunization registry, as applicable, to enable Save Mart/Lucky to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Save Mart/Lucky and its divisions and affiliates and their respective officers, directors, employees, agents, and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Save Mart/Lucky in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.  X  Signature of Person to Receive Vaccine / Parent or Guardian of Minor Date Print name of Parent or Guardian and Phone Number  ***********************************															
answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Save Mart/Lucky, either to me or to the person named above a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Save Mart/Lucky permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or Insurance company or immunization registry, as applicable, to enable Save Mart/Lucky to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Save Mart/Lucky and its divisions and affiliates and their respective officers, directors, employees, agents, and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Save Mart/Lucky in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.  X  Signature of Person to Receive Vaccine / Parent or Guardian of Minor Date Print name of Parent or Guardian and Phone Number  ***********************************															
as I direct Save Mart/Lucky, either to me or to the person named above a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Save Mart/Lucky permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or Insurance company or immunization registry, as applicable, to enable Save Mart/Lucky to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Save Mart/Lucky and its divisions and affiliates and their respective officers, directors, employees, agents, and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Save Mart/Lucky in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.  X  Signature of Person to Receive Vaccine / Parent or Guardian of Minor Date Print name of Parent or Guardian and Phone Number  ***********************************															
Release. I understand that I am giving Save Mart/Lucky permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or Insurance company or immunization registry, as applicable, to enable Save Mart/Lucky to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Save Mart/Lucky and its divisions and affiliates and their respective officers, directors, employees, agents, and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Save Mart/Lucky in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.  X  Signature of Person to Receive Vaccine / Parent or Guardian of Minor Date Print name of Parent or Guardian and Phone Number  ***********************************															
to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Save Mart/Lucky and its divisions and affiliates and their respective officers, directors, employees, agents, and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Save Mart/Lucky in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.  X  Signature of Person to Receive Vaccine / Parent or Guardian of Minor Date Print name of Parent or Guardian and Phone Number  ***********************************					•				•			-			
Save Mart/Lucky and its divisions and affiliates and their respective officers, directors, employees, agents, and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Save Mart/Lucky in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.  X  Signature of Person to Receive Vaccine / Parent or Guardian of Minor Date Print name of Parent or Guardian and Phone Number  ***********************************															
arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Save Mart/Lucky in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.  X  Signature of Person to Receive Vaccine / Parent or Guardian of Minor Date Print name of Parent or Guardian and Phone Number  ***********************************															
Mart/Lucky in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.  X  Signature of Person to Receive Vaccine / Parent or Guardian of Minor Date Print name of Parent or Guardian and Phone Number  ***********************************															
with this vaccination.  X  Signature of Person to Receive Vaccine / Parent or Guardian of Minor Date Print name of Parent or Guardian and Phone Number  ***********************************															
Signature of Person to Receive Vaccine / Parent or Guardian of Minor Date Print name of Parent or Guardian and Phone Number  ***********************************															
**************************************	Х														
Vaccine Lot # Exp Date Mfr Dosage Injection Site Time Date on VIS	Signature	of P	erson to Recei	ve Vaccine / P	arent or Guar	ardian of Minor Date							ne Nu	mber	
			*****	*********	*********Be	Below Line For Pharmacist Use Onl			ly***************************						
Pharmacist Signature:  Date VIS provided to patient:	Vaccine		Lot #	Exp Date	Mfr	Dosage		Injection	Site	Time	Da	te on	VIS		
Pharmacist Signature: Date VIS provided to patient:															
Pharmacist Signature: Date VIS provided to patient:								1							
Pharmacist Signature: Date VIS provided to patient:															
	Pharmacist Signature:				•	•	•	Da	ate VIS pro	vided to	patient:				