Insurance Card: _____ ID: _____ Group: _____ ☐ I do not have insurance

RITE AID

☐ Driver's License State___ #_____ ☐ State ID State___ #_____ ☐ I do not have ID

Screening Questionnaire and Consent Form

Patient Name: _____Date of Birth: _____ Age: _____ Phone#: _____

Address: _____ City: _____ State: ____ Zip: _____ _____ P

☐ ☐

Ethnicity: ☐ Hispanic or Latino(1) ☐ Not Hispanic or Latino(2) ☐ Unknown(3)

Race: ☐ American Indian/Alaska Native(4) ☐ Asian(3) ☐ Native Hawaiian/Other Pacific Islander(5)

☐ Black or African American(1) ☐ White(2) ☐ Unknown(6)

FOR EMERGENCY USE ONLY

Primary Care Physician (PCP): _____ Dr. Phone: _____

PCP address- City _____ State_____Zip Code _____

I authorize the pharmacist to send copies of my vaccine documents to my primary care provider. Yes☐ No☐

"#+-63' 50 4'-'%5 0/' 0(5*'4' $09'4 8+-- 3'46-5+/ 5*' 7#%%+/' &0%6 . '/54 $'+/) 4'/5 50 . : 13+ . #3: %#3' 1307+&'3 +(,/08/ #4 45#5' -#84 3')6-#5+0/4 3'26+3' (03 . : 45#5'!

Are you sick today?			
Do you have a long term health problem with heart disease, kidney disease, metabolic disorder (e.g. diabetes), 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 (i.e. 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 ever had a serious reaction after receiving a 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 a vaccine (e.g. Guill IJ Ꞩ Ꞩ

For women: Are you pregnant or could you become pregnant in the next three months?			
Did you bring your Immunization Record Card with you?			
Are you currently enrolled in one of our medication adherence programs at Rite Aid (OneTrip Refill, Automated Courtesy Refills, or Rx Messaging- Text, Email, Phone)?			

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 Rite Aid.

- 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 reporting.
- I acknowledge that the pharmacist recommends that vaccinated patients should remain in the waiting area, for 15 minutes, after the administration of the immunization.
- I acknowledge receipt of Rite Aid's Notice of Privacy Practices for Protected Health Information.
- I acknowledge that the administration of an immunization or vaccine does not substitute for an annual check-up with the patient's primary care physician.
- For CA: I acknowledge that Rite-Aid intends to share my vaccination record wit l' hot s