St. Teresa Rehabilitation and Nursing Center
Bishop Primeau Senior Living Community
519 Bridge Street
Manchester, NH 03104
T: 603-668-2373
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stteresarehabcenter.org

ST. TERESA REHABILITATION and NURSING CENTER
Bishop Primeau Senior Living Community

October 3, 2021

Hello Residents, staff and families!

It appears that we should be able to give our Pfizer Booster shot this Friday 10/8, Please return consents as soon as possible.

Thanks ,

Luanne Rogers, LNHA
Administrator
St. Teresa Rehabilitation and Nursing Center
519 Bridge Street
Manchester, NH 03104
(603)668-2373 x 4680
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New Hampshire Catholic Charities - Healthcare Services

Influenza Immunization Informed Consent

A Copy of this consent must be filed in the resident's medical record.

Check the appropriate box(s).

RESIDENT

I hereby give my permission to administer an influenza vaccine ***annually*** between October 1 and March 31. I understand that if I have an allergic reaction to the vaccine, those administering the vaccine will promptly provide treatment.

- I have received education on the benefits and potential side effects of the influenza vaccine.
- I have received a copy of the Centers for Disease Control (CDC) Vaccination Information Statement explaining the risks and benefits of the **2021-22** seasonal flu vaccine.
- To the best of my knowledge, I have not had an allergic reaction or anaphylactic reaction to this vaccine or to eggs, sensitivity to thimerosal or an allergic reaction to sodium bisulfate.

☐ **I decline** this immunization even though I am aware of the risks of not receiving it.

- ☐ I have had an allergic reaction or anaphylactic reaction to the influenza vaccine in the past and therefore decline to have this vaccine administered.
- ☐ I have already been immunized for influenza this season and therefore decline to have this vaccine administered.

_____ _____

Signature - Resident Date

_____ _____ _____

Signature – Witness Title Date

_____ _____ _____ _____

Manufacturer Lot Exp. Date VIS Date

RESPONSIBLE PARTY

☐ I, _____ , acting as the ☐ Legal Guardian, ☐ activated Durable Power of Attorney for Healthcare or ☐ Responsible Party of _____

(Name of Resident)

hereby give my permission to administer an influenza vaccine ***annually*** between October 1 and March 31. I understand that if this resident has an allergic reaction to the vaccine, those administering the vaccine will promptly provide treatment.

- I have received education on the benefits and potential side effects of the influenza vaccine for this resident.
- I have received a copy of the Centers for Disease Control (CDC) Vaccination Information Statement explaining the risks and benefits of the **2021-22** seasonal flu vaccine.
- To the best of my knowledge, this resident has not had an allergic reaction or anaphylactic reaction to this vaccine or to eggs, sensitivity to thimerosal or an allergic reaction to sodium bisulfate.

☐ **I decline** this immunization even though I am aware of the risks of not receiving it.

- ☐ This resident has had an allergic reaction or anaphylactic reaction to the influenza vaccine in the past and therefore I decline to have this vaccine administered.
- ☐ This resident has already been immunized for influenza this season and therefore I decline to have this vaccine administered.

_____ _____

Signature – Responsible Party, DPOAHC, Guardian Date

_____ _____ _____

Signature – Witness Title Date

Vaccine Administration Record (VAR)

Informed Consent for Vaccination in Long Term Care Facility (LTCF)

PharMerica®

☐ **Resident** ☐ **Staff** ☐ **Other**

SECTION A-1 Please print clearly.

First name: _____ **Last name:** _____

Gender: ☐ Female ☐ Male ☐ Unk/Undftd

Date of birth: _____ **Age:** _____ **Phone:** _____

Race: _____ ☐ Unknown **Ethnicity:** _____ ☐ Unknown

LTCF Name: _____ **Address:** _____

City: _____ **State:** _____ **ZIP code:** _____ **Patient Email address:** _____

I want to receive the following vaccination(s): ☐ **COVID-19 Vaccination** ☐ **Influenza Vaccination** ☐ **Other Vaccination:** _____

SECTION A-2 I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to PharMerica Corporation and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the vaccine(s)) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Sheet (VIS) or EUA Fact Sheet on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above.

I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Center for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the applicable Provider: (a) the disclosure of my vaccination information by the applicable Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and, to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies, State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State HIE, as applicable.

I understand that even if I do not consent or if I withdraw my consent, my state's laws or federal law may permit certain disclosures of my vaccination information to or through the State HIE or to Government Agencies as required or permitted by law. I further authorize the applicable Provider to: (a) release my medical or other information, including any communicable disease (including HIV), and mental health information, to, or through, the State HIE or Government Agencies to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice. PharMerica Corporation may disclose your vaccination information from this visit for public health purposes and will send this information to the Medical Director or Administrator of the LTCF identified above. If you are an employee of the LTCF, PharMerica Corporation will send your vaccination information to your employer as required. I hereby acknowledge that I have received PharMerica's Notice of Privacy Practices.

Print Name: _____ **Patient/Authorized Person signature:** _____ **Date:** _____

SECTION B-1 **SCREENING QUESTIONS**. The following questions will help us determine your eligibility to be vaccinated today.

1. Have you received a previous dose of COVID-19 vaccine?	☐ Yes ☐ No ☐ Don't know
2. Do you feel sick today?	☐ Yes ☐ No ☐ Don't know
3. In the last 10 days, have you had a COVID-19 test, been exposed to an individual with COVID-19, or traveled?	☐ Yes ☐ No ☐ Don't know
4. Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days?	☐ Yes ☐ No ☐ Don't know
5. Do you have allergies to latex, medications, food, vaccines or any component of vaccines (examples: Polyethylene glycol (PEG) or polysorbate). If yes, please list: _____	☐ Yes ☐ No ☐ Don't know
6. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	☐ Yes ☐ No ☐ Don't know
7. Do you have a bleeding disorder or are you on a blood thinner?	☐ Yes ☐ No ☐ Don't know
8. **For women of childbearing age**: Are you pregnant or considering becoming pregnant in the next month?	☐ Yes ☐ No ☐ Don't know

Recipient Name: _____

SECTION B-2 I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient or representative of; or (c) a representative of the LTCF and, based upon clinical observation, have sufficient knowledge of the patient's condition to answer the Screening Questions. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

Patient/LTCF Representative: _____ **Date:** _____

Responsible Party: _____ **Date:** _____

SECTION B-3 **Check any known conditions the patient has:**

☐ **Blood Disorder** ☐ **Cancer** ☐ **Chronic Lung Disease (e.g. COPD, asthma, etc)** ☐ **Diabetes** ☐ **Heart Disease** ☐ **High Blood Pressure**

☐ **Immunocompromised** ☐ **Kidney Disease** ☐ **Liver Disease** ☐ **Overweight (BMI ≥25 kg/m²)/Obesity (BMI ≥30 kg/m²)** ☐ **Pregnancy** ☐ **Other***

***I attest that I am at high risk of severe COVID-19 disease as defined by the CDC and am eligible for an additional COVID dose** _____
Signature

SECTION B-4 **COVID-19 Vaccine Tracking History (*Pfizer booster dose only authorized if patient received 2 doses of Pfizer as initial vaccine series*)**

Dose 1 _____/_____ **Dose 2** _____/_____
Date/Manufacturer Date/Manufacturer

SECTION C INSURANCE – PATIENT TO COMPLETE IF APPLICABLE

Please ensure to record BOTH pharmacy AND medical insurance information since there are multiple ways immunizations can be billed.

Non-Medicare:	Pharmacy Card	Medical Card
Plan Name:		
Insurance Plan/Plan ID:		
Member/Recipient ID #:		
RX BIN:		
RX PCN:		
Group Number:		
Plan Phone Number:		

Medicare:	Medicare Part B
Medicare Number*:	

*Medicare Claim Number for cards distributed earlier than 2018.

Please provide a photocopy of both sides of your insurance cards and identification.

For residents - Please provide a Face Sheet with relevant demographics and insurance information.

☐ **Uninsured**

Is the patient the cardholder? ☐ Yes ☐ No
If no, please provide cardholders name, date of birth (MM/DD/YYY) and relationship: _____

SECTION D

Complete AFTER vaccine administration

COVID-19 Vaccine Manufacturer	Expiration	Lot Number	Dosage	Site of administration	EUA Fact Sheet/VIS date
				☐ **L** Deltoid ☐ **R** Deltoid ☐ Other:	

☐ Dose 1 ☐ Dose 2 ☐ Dose 3 - Immunocompromised ☐ Dose 3 - Booster

Clinician's name (print): _____ **Clinician's signature:** _____ **Title:** _____

If applicable, intern/tech name (print): _____ **Administration date:** _____ **Date EUA Fact Sheet/VIS given to patient:** _____

Influenza Vaccine Manufacturer	Expiration	Lot Number	Dosage	Site of administration	VIS published date
				☐ **L** Deltoid ☐ **R** Deltoid ☐ Other:	

Clinician's name (print): _____ **Clinician's signature:** _____ **Title:** _____

If applicable, intern/tech name (print): _____ **Administration date:** _____ **Date VIS given to patient:** _____

Other Vaccine:	Expiration	Lot Number	Dosage	Site of administration	VIS published date
Manufacturer:				☐ **L** Deltoid ☐ **R** Deltoid ☐ Other:	

Clinician's name (print): _____ **Clinician's signature:** _____ **Title:** _____

If applicable, intern/tech name (print): _____ **Administration date:** _____ **Date VIS given to patient:** _____

1. Update the patient's record with any new allergy, health condition or primary care provider information.
2. Enter vaccine lot #, expiration date and site of administration, then scan the VAR form into the patient's record.