Informed Consent for Immunization with COVID-19 Vaccine

First Name: _____ Last Name: _____ Date of Birth: _____ Age: ____**see below
Gender: _____ Phone # _____ Shot Requested Today: _____ 1st Dose / 2nd Dose / Booster
Previously Given: Pfizer / Moderna / Johnson Date of Last Dose: _____ Reaction? _____
Home Address: _____ **if under 65, please list qualification for COVID-19 vaccine:
City: _____ State: _____ Zip: _____ (health condition, disease state, high risk job) _____
Known Allergies: _____ _____

Race: ☐Asian ☐Black/African American ☐Hispanic ☐Native American ☐Caucasian ☐Pacific Islander ☐Other

Ethnicity: ☐Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline to State (Unknown)

Screening Questionnaire: *Please Answer questions by checking boxes*		Yes	No
1.	Are you sick today?		
2.	a. Have you ever had an allergic reaction to: (This would include a severe allergic reaction (e.g. anaphylaxis) that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital, and includes an allergic reaction that caused hives, swelling, or respiratory distress (including wheezing) b. A reaction to a component of a COVID-19 vaccine, including either of the following: - - Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures - - Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids?		
3.	Have you ever had an allergic reaction to any vaccine? If yes, which vaccine? _____		
4.	Check all that apply:		
	- Am a female between ages 18 to 49 years old		
	- Am a male between ages 12 and 29 years old		
	- Have a history of myocarditis or pericarditis		
	- Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental, or oral medications		
	- Had COVID-19 and was treated with monoclonal antibodies or convalescent serum		
	- Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection		
	- Have a weakened immune system (HIV, cancer) or take immunosuppressive drugs or therapies		
	- Have a bleeding disorder		
	- Have a history of heparin-induced thrombocytopenia (HIT)		
	- Am a currently pregnant or breastfeeding		
	- Have received dermal fillers		
	- History of Guillain-Barre Syndrome (GBS)		
5.	Any recent vaccines given? ☐ Flu ☐ Prevnar 13 ☐Pneumovax ☐Zostavax Date Received: _____		

Insurance:
Medicare? Part B (Red, White, blue Card #) / Last 4 digit of SSN -----> _____
Commercial? _____

Informed Consent: Please read and sign.

By my signature below, I consent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist or technician, or other authorized person, where permitted by law or state/federal guidance, employed, or contracted by North Falmouth Pharmacy and to be contacted at the number provided above regarding other immunizations for which I am due or eligible to receive. I also release North Falmouth Pharmacy and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting, or arising from my receipt of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination and understand that I am obligated to pay for all products and services received, if applicable. 2) I may be responsible for payment after the date of service if the product or service is billed to my medical benefit. 3) I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient 4) I will immediately alert the pharmacist of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine. 5) I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects. 6) I should remain in observation for 15 minutes unless I have a history of an immediate allergic reaction of any severity to a vaccine or injectable therapy or if I have a history or anaphylaxis in which case, I should remain in observation for 30 minutes. If I leave the area without waiting, I acknowledge that I am doing so at my own risk against the advice of the professional who administered the vaccine. 7) I have read, or have read to me, the Vaccine Information Sheet (VIS) or Emergency Use Authorization (EUA) provided for the vaccine(s) administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the risks and benefits of the vaccine(s) 8) I have been offered and/or provided a copy of the company's Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act (HIPPA) 9) This vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting by my pharmacy or its business associate to an immunization registry, which may share my immunization data with others, and to my primary care physician, or the local Department of Health, if applicable, and I authorize these disclosures.

→ Signature of Patient or Parent/Guardian of Minor Patient: _____ Date: _____

For Pharmacy Use Only: Given by: _____ Administration Date: _____ ☐NPP Rph offered counseling: accepted/declined.
RPH Signature indicates (1) VIS/EUA provided (2) Counseling offered and (3) Patient Eligibility Verified): _____
Booster Given: PFIZER or MODERNA
NDC: _____
LOT #: _____
Exp: _____
Arm: Left / Right

Vaccine documentation and consent form

Section 1: Patient information

Patient name (First, middle initial, last) _____

Company name *(if applicable)* _____ Employee ID _____

DOB (MM/DD/YY) _____

Address _____

City _____ State _____ Zip Code _____

✓	VACCINE	VIS DATE	✓	VACCINE	VIS DATE
	RSV			Polio (IPV)	
	Cholera			Rabies	
	Hepatitis A			Rotavirus	
	Hepatitis B			Serogroup B Meningococcal (MenB)	
	Human Papilloma Virus (HPV)			Smallpox	
	Japanese Encephalitis			Tetanus and Diphtheria (Td)	
	Influenza (Flu)			Tetanus, Diphtheria, & Pertussis (TDaP or DTaP)	
	Measles, Mumps & Rubella (MMR)			Typhoid	
	Measles, Mumps, Rubella & Varicella (MMRV)			Varicella (Chickenpox)	
	Meningococcal ACWY (Meningitis)			Yellow Fever	
	Pneumococcal Conjugate PCVI3 (Pneumonia)			Zoster/Shingles (Recombinant)	
	Pneumococcal Polysaccharide PPSV23 (Pneumonia)			Zoster/Shingles (Live)	

Section 2: Immunization screening questionnaire

1. Have you had any allergic or adverse reaction to any vaccination? ☐Yes ☐No
   If Yes, please list: _____
2. Are you currently taking any medications? ☐Yes ☐No
   If Yes, please list: _____
3. Have you ever had an allergic reaction to any medication(s)? ☐Yes ☐No
   If Yes, please list: _____
4. Have you ever had an allergic reaction to any food? ☐Yes ☐No
   If Yes, please list: _____
5. Do you have an allergy to latex? ☐Yes ☐No
6. Have you ever had any other allergies or allergic reactions, in addition to those described above? ☐Yes ☐No
   If Yes, please list: _____
7. Have you been sick or had a fever of 101 degrees F or higher in the past 48 hours? ☐Yes ☐No
8. Have you had a seizure or other neurological problems? ☐Yes ☐No

continued on next page

9. Do you have (or is there a risk that you have) cancer, leukemia, HIV, AIDS or any other immune system problem? ☐Yes ☐No

10. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? ☐Yes ☐No

11. During the past 12 months, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? ☐Yes ☐No

12. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? ☐Yes ☐No

13. Have you received any vaccinations in the past 4 weeks? ☐Yes ☐No

14. *For women:* Are you pregnant or is there a chance that you could become pregnant during the next 30 days? ☐Yes ☐No

15. *For women:* When was the first day of your last menstrual period? Date _____ ☐N/A

Section 3: Physician information

STATES THAT REQUIRE PCP NOTIFICATION

Physician name _____

Physician phone _____

Physician fax _____

Section 4: Patient consent and signature

I GIVE CONSENT to the _____ and its staff to vaccinate me with this vaccine. I FULLY UNDERSTAND THAT I WILL BE ULTIMATELY RESPONSIBLE FOR ANY CHARGES if I am not a covered person under the insurance plan (program listed above), the services are not covered services, or any co-pays, deductibles or coinsurance obligations apply.

Signature _____

Print name _____

Relationship to patient _____

Date of service _____

Section 5: Pharmacy use only

VACCINE	SITE	LOCATION	LOT #	EXP DATE
1.	R / L			
2.	R / L			
3.	R / L			
4.	R / L			

Admin initials _____

Your Locally Owned Health Mart PHARMACY