# OAKSIDE CARE PHARMACY

# COVID-19 Vaccine Consent Form ( 5 to 11 )

 **Patient Information (Vaccine Recipient)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** (Last) | (First) | **DOB** | **Gender** |
| **Address** | **Address 2** |
| **City** | **State** | **Zip** | **Phone** |
| **Race** | **Ethnicity** |
| **Primary Care Provider Name:** | **Weight** |
| **Emergency****Contact Name:** | **Emergency****Contact Relation:** | **Emergency****Contact Phone:** |

 **Select which dose you are receiving (circle one): 1st Dose | 2nd Dose | Additional Dose | Booster Dose**

 **If applicable, which vaccine product did you receive last (circle one): Pfizer | Moderna**

# Screening Questions

|  |  |  |  |
| --- | --- | --- | --- |
| **Question** | **YES** | **NO** | **Don’t****Know** |
| Are you feeling sick today? |  |  |  |
| Have you ever received a dose of COVID-19 Vaccine?If yes, which did you receive: |  |  |  |
| Have you ever had an allergic reaction to a component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations forcolonoscopy procedures? |  |  |  |
| Have you ever had an allergic reaction to Polysorbate, which is found in some vaccines, film-coatedtablets and intravenous steroids? |  |  |  |
| Have you ever had an allergic reaction to a previous dose of COVID-19 Vaccine? |  |  |  |
| Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? *(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. It would also include and allergic**reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)* |  |  |  |
| Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a componentof COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies. |  |  |  |
| Have you received any vaccine in the last 14 days?If yes, which did you receive: |  |  |  |
| Have you ever had a positive test for COVID-19 or has a health care provider ever told you that youhad COVID-19? |  |  |  |
| Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? If yes, when did you receive antibody therapy: |  |  |  |
| Do you have a weakened immune system caused by something such as HIV infection or cancer or doyou take immunosuppressive drugs or therapies? |  |  |  |
| Do you have a bleeding disorder or are you taking a blood thinner? |  |  |  |
|  Do you have a history of myocarditis or pericarditis? |  |  |  |
|  Do you have a history of Guillain-Barre Syndrome (GBS)? |  |  |  |
| Have you been diagnosed with Multisystem Inflammatory Syndrome after a COVID19 infection? |  |  |  |

**Consent (check each box below after reading and signing)**

* I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet, a copy of which I was provided with this Consent Form. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent Form.
* I understand that at this time, some COVID-19 vaccines require 2 doses given 21-28 days apart dependent on the manufacturer. If this is my first dose of the COVID-19 vaccine and a second dose is required (Pfizer and Moderna only), I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the series.
* I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur.
* I understand that I will be receiving the vaccination at no cost to me.

 **Select One of the Following:**

* If INSURED, check this box attesting to bringing in your **prescription and medical insurance cards** for your vaccine appointment. By selecting this, you are also authorizing the pharmacy to bill your insurance on your behalf for the immunization – understanding you will not incur any costs.
* If UNINSURED, you must check this box to attest that the following information is true and accurate: I do not have any insurance, including but not limited to, Medicare, Medicaid, or any other private or government-funded benefit plan.

For uninsured patients, please select one of the following that you will present at the pharmacy. *This is needed, but not required, to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program.*

Pharmacy Use for Insurance Information

* + Social Security Number
	+ State identification number & state of issuance
	+ Driver's license number & state of issuance

**Signature of Person to Receive Vaccine & EUA /VIS (or Signature of Parent/Guardian if Patient is < 18 years old)**

**Signature: Date:**

***\*\*PHARMACY USE ONLY\*\****

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Vaccine** | **Dose** | **Route** | **Date Dose****Administered** | **Vaccine****Manufacturer** | **Lot****Number** | **Expiration****Date** | **Name of Vaccine****Administrator** |
| COVID- 19 | * 1st Dose
 | * IM - L Arm
* IM - R Arm
 |  | * Pfizer
 |  |  |  |
| COVID- 19 | * 2nd Dose
 | * IM - L Arm
* IM - R Arm
 |  | * Pfizer
 |  |  |  |
|  |   |  |  |  |  |  |  |

**Reason for additional or booster dose (***if applicable)***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacist Name** who reviewed this form: **Pharmacist Signature**:

**If certified vaccinator** is different than the pharmacist who reviewed the form:

**Name**:

**Signature**: