538 Penn Ave
301 S 7th Ave Suite 145
301 S 7th Ave Suite 146
West Reading, PA 19611

West Reading Drug Store
Esterbrook Pharmacy
Outlook Pharmacy Services

Pharmacy Use Only
Dose 3
SIIS ☐ Rx30☐ Billed ☐

COVID-19 Vaccine Booster Dose Consent Form

Section 1: Information about Patient to Receive COVID-19 Vaccine *(please print)* *ALL FIELDS REQUIRED

PATIENT'S NAME (Last)	(First)	**DATE OF BIRTH** _____/_____/_____ **(mm / dd / yyyy)**	**GENDER** **M / F**	**ETHNICITY (please circle)** **Asian Black/African American Hispanic/Latino White Other**
ADDRESS		**CITY**	**STATE**	**ZIP**
PHONE		**EMAIL**		**AGE (12+ only)**
INSURANCE (non-Medicare)	**RxBIN_____ RxPCN:_____ RxGroup:_____ ID:_____**	**MEDICARE BENEFICIARIES*** **ID:_____ OR Last 4 SSN: _____** ***Red, White & Blue Card**		

Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if you are eligible to receive a booster dose of the COVID-19 vaccine today.
Please check YES or NO for each question.

	YES	**NO**
1. Are you feeling sick today?	☐	☐
2. Have you ever received a dose of any COVID-19 vaccine? If so, which product? Pfizer Moderna J&J Other_____	☐	☐
3. Do you have any allergies to medications, food, latex, or vaccine components (**polyethylene glycol** and **polysorbate** are ingredients of COVID-19 vaccine products—individuals with an allergy to one or both of these ingredients should consult a physician before vaccination)?	☐	☐
4. Have you ever had a severe allergic reaction (i.e anaphylaxis)? For example, a reaction for which you were treated with an EpiPen (epinephrine) or for which you had to go to a hospital? Was the severe allergic reaction from -- A previous COVID-19 vaccine? Another vaccine, injectable medication, or shellfish?	☐ ☐ ☐	☐ ☐ ☐
5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19?	☐	☐
6. Have you received another vaccine in the last 14 days?	☐	☐
7. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐
8. Do you have a weakened immune system caused by something such as HIV Infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐
9. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐
10. Are you pregnant or breastfeeding?	☐	☐

By signing below, I give consent to West Reading Drug Store, Esterbrook Pharmacy and Outlook Pharmacy Services and its staff, to vaccinate me with the COVID-19 vaccine series/booster dose, and to report any data collected on this form to the required State and/or Federal agencies as required (if this consent form is not signed, then the patient will not be vaccinated). **I** also **agree to hold harmless West Reading Drug Store, Esterbrook Pharmacy and Outlook Pharmacy Services**, its directors, officers, employees, agents, and stockholders **from and against all claims, demands, actions, suits, damages, liabilities, losses, settlements, judgments, costs and expenses (including but not limited to reasonable attorney fees and costs), whether or not involving a third-party claim, which may arise out of, or relate to, the administration of this vaccine.**

Booster Dose Timing: **J&J** (2 months after 1st dose), **Pfizer*** (5 months after 2nd dose), **Moderna** (6 months after 2nd dose)
***patients **under age 18 MUST** receive the Pfizer (age 12+) vaccine as their booster dose

Date(s) of primary COVID-19 Vaccination: DOSE 1: ____/____/____ DOSE 2: ____/____/____

Patient Signature _____ **Date**: ____/____/____
(Parent/Guardian Signature if age <18)

Section 3: Vaccination Record (Pharmacy Use Only)

Screening Questions Reviewed by: _____

Vaccine	**Route (I.M.) Deltoid**	**Date Administered**	**Vaccine Manufacturer**	**Lot / Exp**	**Vaccinator Name**
COVID-19	☐ Left ☐ Right	/ /	J&J Moderna Pfizer	/	