



Randolph 1447247846 Gorham 1538156807 Cornish 1760587232
 Bucksport 1881681286 Corinth 1700873122 Waldoboro 1124362934
 Saco 1275520686 Blue Hill 1013961549 Hermon 1538536180

VACCINE CONSENT & ADMINISTRATION RECORD

Last Name:		First Name:		MI:	Gender: (assigned at birth) <input type="radio"/> Male <input type="radio"/> Female	
Address:			City:		State:	Zip Code:
Phone Number: <input type="radio"/> Cell <input type="radio"/> Home		Primary Care Provider:		Date of Birth:		Age In Years:
Race <input type="radio"/> White <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Asian **Required		<input type="radio"/> Native Hawaiian or other Pacific Islander <input type="radio"/> Black or African American <input type="radio"/> Other		Ethnicity <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino <input type="radio"/> Unknown **Required		

INSURANCE CARD, LICENSE or ID REQUIRED

Medicare Eligible? Yes No		If yes, Medicare B Number: (red, white & blue card)		OR	Social Security #:	AND	License or State ID:
Prescription Insurance Name:		Member ID Number:	Rx BIN:	Rx PCN:		Rx Group:	
Uninsured? Yes No By selecting YES I am attesting that I do not have insurance		License or Social Security Number Required:				Staff—Information Verified? Yes: _____ Initials: _____	

Please read and answer the questions below for the person receiving the vaccine(s) today	YES	NO	Don't Know	Comment
1- Do you feel sick today?	_____	_____	_____	_____
2- Do you have allergies to medications, food latex or any vaccines?	_____	_____	_____	_____
3- Have you ever had a serious reaction after receiving a vaccination?	_____	_____	_____	_____
4- Do you have cancer, leukemia, AIDS, or any other immune system problem?	_____	_____	_____	_____
5- Do you take cortisone, prednisone, or other steroids or anticancer drugs, or xray treatments?	_____	_____	_____	_____
6- Do you have a seizure, brain or nerve problem?	_____	_____	_____	_____
7- During the past year, have you received a transfusion of blood or blood products?	_____	_____	_____	_____
8- Have you been given a medicine called immune (gamma) globulin?	_____	_____	_____	_____
9- Have you been diagnosed or tested positive for COVID-19 in the last 14 days?	_____	_____	_____	_____
10- In the past 14 days have you been identified as a close contact to someone with COVID-19?	_____	_____	_____	_____
11- For women: Are you pregnant or is there a chance you could become pregnant in the next month?	_____	_____	_____	_____
12- Have you received <u>any other</u> vaccinations in the past 4 weeks. Ex: pneumonia, shingles, flu.....	_____	_____	_____	_____
13- Is this your 1st, 2nd, 3rd, 4th or 5th dose of the COVID-19 vaccine?(Circle one)	1st	2nd	3rd	4th 5th

Please read the following statements and sign below:

I have read, or have had read to me, the information regarding the vaccine(s) being administered today. I have had the opportunity to ask questions that were answered to my satisfaction. I have been informed to wait at least 15 minutes after vaccine administration. I give my permission for the pharmacist providing this immunization to administer epinephrine, diphenhydramine, or both, to me in the case of an adverse reaction to the drug or immunization administered. I understand the benefits and risks of the vaccine(s). I acknowledge that I have been offered a copy of the pharmacy's Notice of Privacy Policies. I consent to, or give consent for, the administration of the vaccine.

Signature: _____ **Date:** _____

For Clinic Use:	
Date Administered:	8/24/2022
Vaccine Name:	COVID-19
Manufacturer:	Pfizer Moderna J&J
Lot Number:	
Expiration Date:	
Route:	IM
Site:	LD RD LVL RVL
Dose:	0.2ml 0.25ml 0.3ml 0.5ml
EUA VIS Version (pub date):	
Date and to whom EUA VIS provided:	
Vaccine Administrator:	Initial:

Yarmouth Clinic
08-24-2022

Pharmacy Label