COVID-19 Vaccine Consent Form — Janssen

Site of Administration: ☐ Medicine Stop Pharmacy 1544 Watson Blvd, Warner Robins, GA 31093 ☐ Unadilla Drug Company 413 2nd St, Unadilla GA 31091

Name:	Birthday:	Age:
Address:	City, State & Zip:	
Phone:	Email Address:	
Emergency Contact (name and phone number):	SSN/Medicare:	
Primary Care Physician:	TRICARE SPONSOR SSN:	

Gender	Ethnicity	Race
☐ Male ☐ Female	☐ Hispanic ☐ Unknown ☐ Not Hispanic	☐ Asian/Polynesian ☐ White ☐ Native American/Alaskan ☐ Black ☐ Multiracial ☐ Unknown

Precautions and Contraindications: Please mark YES or NO for each question	YES	NO
Are you sick today or currently in an isolation or quarantine period?		
Have you ever received a dose of COVID-19 vaccine?		
If yes, which vaccine? ☐ Pfizer ☐ Moderna Date received: _____		
Have you received passive antibody therapy as treatment for COVID-19?		
Have you ever had a severe allergic reaction to:		
Polyethylene glycol, commonly found in laxatives, and colonoscopy preps?		
Polysorbate?		
Any other vaccines or injectable medications?		
Anything else?		
Have you received any vaccines in the past 14 days?		
Do you have a bleeding disorder or are you taking a blood thinner?		
Do you currently have a weakened immune system, take immunosuppressive medications, or receive radiation or chemotherapy treatment?		
Are you pregnant or currently breastfeeding?		
Do you consent for vaccine registry to share with other providers? ***(Required to receive vaccine)***		
WOULD YOU PREFER THE VACCINE IN LEFT OR RIGHT ARM?	L	R

- I have been given a copy and have read, or have had explained to me, the information in the FACT SHEET for the COVID-19 vaccine. I understand the FDA has authorized emergency use of the COVID-19 vaccine, which is not an FDA-approved vaccine. I have had the chance to ask questions that were answered to my satisfaction.
- I understand the COVID-19 vaccine requires 2 doses given 4 weeks apart. If this is my first dose of the COVID-19 vaccine, I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the FACT SHEET to complete the vaccination series.
- My signature acknowledges that I was advised to remain on site for 15 minutes after receiving the vaccine. Those with a history of previous anaphylactic reactions should stay on site for 30 minutes. I understand that if I experience any adverse reaction, it will be my responsibility to follow up with my primary care physician.
- An administration fee may be billed to third party payers. I authorize Medicine Stop Pharmacy and/or Unadilla Drug Company to bill any and all third party payers for this service. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits or payment of medical benefits either to myself or to the party who accepts assignment for services described herein.
- I understand the significant known and potential risks and benefits of the COVID-19 vaccine as explained in the FACT SHEET and that some potential risks and benefits may remain unknown. I REQUEST THE COVID-19 VACCINE BE GIVEN TO ME OR THE PERSON LISTED ABOVE

Patient/Guardian Signature:	Date:

**********Pharmacy Use Only**********

Administrator Signature:	Date:

Vaccine name, Dose, Lot no, Exp date	Administrator			
Janssen COVID-19 Vaccine 0.5mL Lot: 201A21A Exp: Jun 23, 2021	☐ Jasmine Crockett RPH026322	☐ Linda Durden, RN RN21338	☐ Sheila Hart, RN RN129819	☐ Bonnie Henderson, RN RN080217
	☐ Melinda Maddox RN066134	☐ Dhara Patel RPH025118	☐ Tej Patel RPH032308	☐ Vinh Tran RPH025411
	☐ Candice White RPH027039	☐ Kristin Williams PHTC032129		