COVID-19 Vaccine Consent Form

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:		

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 had a positive COVID-19 test in the last 90 days?		
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 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?		
Consent to let registry 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**********

Provider Signature:	Date:

Vaccine name, Dose, Lot no, Exp date	Administration		Administrator	
☐ Moderna COVID-19 Vaccine 0.5mL	GRITS	Route	☐ Dhara Patel	☐ Tej Patel
☐ Janssen COVID-19 Vaccine 0.5mL	☐	IM	025118	032308
Lot:	CASH	INPUT	☐ Vinh Tom Tran	☐ Jasmine Crockett
Exp:	☐	☐	025411	026322
			☐ Candice White	☐ Linda Durden, RN
			027039	RN21338