COVID-19 Consent Form v 12.2021

SECTION A. Please print clearly.

First name: ______________________________ Last name: ______________________________

Date of Birth: ____________ Age: ________ Gender: ☐ Female ☐ Male Phone: ______________________

Home address: ______________________ City: __________ State: ______ Zip Code: ____________

Driver's License/ State ID#: ______________________ Email address: ______________________

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐ White ☐ Other Race: __________ ☐ Prefer to not disclose.

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ethnicity

Doctor/Primary care provider name: ______________________ Phone: ______________________

Emergency Contact: ______________________ Relation: ______________ Phone: ______________________

Mother's First Name: ______________________ Allergy: ______________________

SECTION B

Question	Response
1. Are you feeling sick?	☐ Yes ☐ No ☐ Don't know
2. Have you ever received a dose of COVID-19 Vaccine? IF YES, ANSWER BELOW • If you have received a dose of COVID-19 Vaccine before: • Vaccine manufacturer (IE. Pfizer, Moderna, etc): ______________ Date of the last dose: ______________	☐ Yes ☐ No ☐ Don't know
3. Have you ever had an allergic reaction to: (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 an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medication, such as laxatives and preparation for colonoscopy procedures or polysorbate.	☐ Yes ☐ No ☐ Don't know
• A previous dose of COVID-19 vaccine.	☐ Yes ☐ No ☐ Don't know
4. 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 an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐ Yes ☐ No ☐ Don't know
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? (This would include food, pet, environmental, or oral medication allergies.)	☐ Yes ☐ No ☐ Don't know
6. Have you received any vaccine in the last 14 days?	☐ Yes ☐ No ☐ Don't know
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drug or therapies?	☐ Yes ☐ No ☐ Don't know
8. Have you been diagnosed with Multisystem Inflammatory Syndrome (MISC-C or MIS-A) after COVID infection?	☐ Yes ☐ No ☐ Don't know
9 Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID? (Note: monoclonal antibodies do not include antibodies that would be prescribed to you and filled at a pharmacy)	☐ Yes ☐ No ☐ Don't know
10 Do you have a bleeding disorder or are you taking a blood thinner or a history of heparin-induced thrombocytopenia (HIT)?	☐ Yes ☐ No ☐ Don't know
11 Are you pregnant or breastfeeding?	☐ Yes ☐ No ☐ Don't know
12 Do you have a history of myocarditis or pericarditis?	☐ Yes ☐ No ☐ Don't know
13 Have you received dermal fillers?	☐ Yes ☐ No ☐ Don't Know
14 Do you have a history of Guillain-Barré Syndrome (GBS), a condition that causes paralysis?	☐ Yes ☐ No ☐ Don't Know
15. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving the COVID-19 Vaccine?	☐ Yes ☐ No ☐ Don't Know

SECTION C

- I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. I hereby give my consent to the Pharmacy and the licensed healthcare professional administering the vaccine as applicable (each an "applicable Provider"), to administer the vaccine(s).
- I understand the benefits and risk of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact sheet or FDA Approved 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 agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the applicable provider after receiving my vaccine to ensure that no immediate adverse reactions occur.
- I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless each applicable Provider, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s).
- I understand that the applicable Provider may be required to or may voluntarily disclose my health information with respect of this vaccine to my healthcare providers, my insurance plan, health systems and hospitals, and/or state or federal registries. I understand that the applicable Provider will use and disclose my health information as set forth in the Notice of Privacy Practices (copy is available in store or by requesting a paper copy from the pharmacy). By signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies, STATE IIS and/or State Registry to the entities and for the purpose described in this Informed Consent form.
- I understand that I will be receiving the vaccination at no cost to me. (Check all that apply)
  - ☐ If insured, I will bring my medical insurance card(s) for my vaccine appointment and authorize the applicable Provider to bill my insurance on behalf for the immunization administration.
  - ☐ If uninsured, I attest that I do not have any insurance including but not limited to, Medicare, Medicaid or any other private or government funded plan and will bring Driver's License or State issued ID.

Patient Signature: ______________________________ (Parent or guardian if minor)

__________________________ Relation to the minor

Print Name: ____Date:_________________

PHARMACY USE ONLY

Patient Age: ___________________

Eligibility Criteria Met: ☐ YES ☐ NO

Vaccine	Lot Number	Expiration Date	Route/Administration Site:	Date of Administration	Time Dose Administered
COVID -19			☐ IM – L ARM ☐ IM – R ARM		_____:_____

Vaccine Manufacturer	Dose #	Volume
☐ PFIZER	☐ 1ST ☐ 2ND ☐ 3RD ☐ BOOSTER	☐ 0.3 mL
☐ PFIZER (PEDIATRIC)	☐ 1ST ☐ 2ND	☐ 0.2 mL
☐ MODERNA	☐ 1ST ☐ 2ND ☐ 3RD ☐ BOOSTER	☐ 0.5 mL **BOOSTER ONLY** ☐ 0.25 mL
☐ JANSSEN	☐ 1ST ☐ BOOSTER	☐ 0.5 mL

Name of Vaccine Administrator :	VIS/EUA From Provided: ☐

____ Pharmacist Name (who reviewed this form and approved this dose)

__________________________ Date