Brown's ADVANCED Care Pharmacy Services | Country Market Pharmacy | Hudson Pharmacy | SCHMIDT & SONS PHARMACY

COVID-19 VACCINE CONSENT FORM AND PREVACCINATION CHECKLIST

Last Name: _____ First Name: _____ Sex: Male Female

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____ Age: _____

Physician: _____ Last 4 numbers of Social Security number _____

Race: __ White __African American __Asian __ Hispanic/Latino __ Native Hawaiian/Other Pacific Islander __American Indian/Alaska Native

Not all individuals requesting a vaccine can safely be immunized. The following questions will help us determine if there is any reason you should not get the Covid vaccine today. **Answering yes to any question does not necessarily mean you should not be vaccinated:**

	Yes	No	Unsure
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Jannsen (Johnson & Johnson) ☐ Another Product			
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 medications, such as laxatives and preparations for colonoscopy procedures			
• Polysorbate			
• A previous dose of COVID-19 vaccine			
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)			
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			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received a passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Having received an explanation and informed consent, I hereby agree to release and hold Advanced Care Provider Network, its employees, agents and representatives harmless from further responsibility with regard to my receiving the injections.
I have received and read the EUA Patient Information Sheet (dated _____) I understand the benefits and risks of the vaccine(s) I am receiving today. I request the vaccine(s) be administered to me or to the person named for whom I am authorized to sign.

_____ _____

Signature: Patient or Authorized Representative Date

I request that this provider be paid authorized Medicare/Medicaid/Private Insurance benefits on my behalf for any services furnished to me. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services. **I understand that I am responsible for the charges if my Medicare/Medicaid/Private Insurance coverage is not appropriate.**

Medicare Number_____ Medicaid_____ Private _____
(For all Private Insurance Companies please include copy of front and back of insurance card)

Policy Number (including alpha characters) _____ Group Number _____

Patient or Authorized Rep Signature _____ __Payment to Patient √ **Payment to Provider**

For Pharmacy Use:

Immunizer Signature _____ **Date** _____

Lot Number _____ **Brand**_____ **IM Administration Site:** **Left Deltoid** ☐ **Right Deltoid** ☐ **MCIR** ☐ **BILLED** ☐