ImmTrac#:		Date:
		Facility:

Garland Independent Pharmacy
3641 Broadway Blvd #100 Garland, TX 75043 (972) 864-1110

COVID VACCINE INTAKE CONSENT FORM

M/F/Unknown

Name (First and Last) | Date of Birth | Gender

Address | City | State | Zip | County

Phone Number | Email

Social Security Number | State or driver's identification number/State of Issuance

Prescription Insurance:

☐ **Private Insurance:**

Prescription Benefit Plan Name | Cardholder ID# | Rx BIN | PCN | Group

Are you the primary cardholder? **Yes** **No**

If no, name and date of birth of primary cardholder: _____

☐ **Medicare:**

Name as it appears on Card _____

New Medicare Number _____

☐ **No Insurance:**

If uninsured, you must check the box below to attest that the following information is true:

- I do not have any insurance, including but not limited to Medicare, Medicaid, or any other private or government-funded health benefit plan.

In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, please provide either (a) a valid Social Security number AND (b) state identification (or driver's license) number and state of issuance.

Patient Race (select one):

- American Indian or Alaska Native
- Asian
- Native Hawaiian/Other Pacific Islander
- Black or African American
- White
- Other

Patient Ethnicity (select one):

- Hispanic
- Not Hispanic or Latino
- Unknown

Please Complete Second Page

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Potential Contraindications (please circle):

1. Are you feeling sick today? **Yes** **No**
2. Have you ever received a dose of COVID-19 vaccine? **Yes** **No**
    a. If yes, please circle which one: **Pfizer** **Moderna** **Other**
3. Have you ever had a severe allergic reaction in the past that required treatment with EpiPen or at a hospital? **Yes** **No**
    a. **Was the severe allergic reaction after receiving a COVID-19 vaccine? Yes No**
    b. **Was the severe allergic reaction after exposure to Polyethylene Glycol (PEG) commonly found in bowel preps and laxatives? Yes No**
4. Have you received any vaccines in the past 14 days? **Yes** **No**
5. Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days? **Yes** **No**
6. Do you have a bleeding disorder or are you taking a blood thinner? **Yes** **No**
7. Do you have a weakened immune system or currently take medications that can diminish your immune response (HIV medications, steroids, anticancer drugs, radiation treatment, etc)? **Yes** **No**
8. For women, are you currently pregnant or breastfeeding? **Yes** **No**

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet(s) or patient fact sheet corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand that if I experience side effects that I should: call pharmacy, contact doctor, call 911. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize Garland Independent Pharmacy (GIP) to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid, or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS: I understand that GIP may be required to or may voluntarily disclose my health information to the physician responsible for this protocol or specific health information of people vaccinated at GIP, my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that GIP will use and disclose my health information as set forth in the GIP Notice of Privacy Practices (copy available by request).

X_____

Signature of patient to receive vaccine (or parent, guardian, or authorized representative) Date

Printed name of patient (or parent, guardian, or authorized representative) Phone # Relationship

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FOR PHARMACY USE ONLY

	COVID-19	Moderna or Pfizer	0.5 or 0.3
Administration Date	Vaccine	Manufacturer	Volume(mL)

_____	IM_____	LD/RD	First Dose
Lot #	Route		

_____

Administering Immunizer Name, Title, Signature

_____

SECOND DOSE ONLY

	COVID-19	Moderna or Pfizer	0.5 or 0.3
Administration Date	Vaccine	Manufacturer	Volume(mL)

_____	IM_____	LD/RD	Second Dose
Lot #	Route		

_____

Administering Immunizer Name, Title, Signature

_____

Date (Second Dose)

Patient ImmTrac Group

- GPT1: Pregnant or less than 35 months old
- GPT2: Household contacts of infants under 6 months old; High-risk children age 3-18 years
- GPT3: Children age 3-18 years without high-risk indications
- GPT4: High-risk adults age 19-64; Adults over age 65
- GPT5: Healthy adults age 19-64