Gurley Family Pharmacies
COVID-19 Vaccine Consent Form

Last Name	First Name	M.I.	Gender Race
Last 4 Digits of Social Security Number	Date of Birth	Age	County
Address			Phone

Vaccine Administration Information

Question	
Are you feeling sick today?	Yes No
Have you ever received a COVID-19 vaccination? If yes, date given_______________ Manufacturer_______________	Yes No
Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? A reaction in which you were treated with an EpiPen?	Yes No
Do you have allergies to eggs, thimerosal, gelatin, neomycin, phenol or bovine protein? If yes, list: _______________	Yes No
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for CoVID-19? If yes, when_________	Yes No
Have you received another vaccine in the last 14 days? If so, which vaccine _______________	Yes No
Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? If yes, when _______________	Yes No
Do you have long-term health problems with: •immunocompromised condition or taking a medicine that affects your immune system? (Heart Disease • Lung Disease • Asthma • Kidney or Liver Disease • Metabolic Disease, such as Diabetes • Bleeding disorder or take a blood thinner) **IF YES, PLEASE CIRCLE CONDITIONS ABOVE -OR- LIST HERE:**	Yes No
Do you have a bleeding disorder or take a blood thinner? If yes, please list _______________	Yes No
For Women: Are you pregnant or considering becoming pregnant in the next three months, or currently nursing?	Yes No
Have you had a seizure or any other brain or other nervous system problem (i.e., Guillain-Barré Syndrome) after receiving a vaccine?	Yes No

Consent for services, HIPAA Privacy Information and Medical Records

I have been provided with the Vaccine Information Sheet (VIS) or Emergency Use Authorization (EUA) and/or been provided with information regarding to the vaccine I am receiving. I understand all the benefits and risks of the vaccine and have had the chance to ask questions regarding it. I voluntarily assume full responsibility for any reactions that may result. I request the vaccine be given to me and authorize and direct this health care provider to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated by this provider (standing order practitioner (Dr. John Clark Hill), my Primary Care Physician (PCP), my insurance plan and/or state federal registries, where required for purposes of treatment, payment or other health care operations. This only allows this provider to disclose the following medical records: only documents related to the vaccination received today. This authorization will remain in effect until my health care provider discloses my health information to the recipient identified above; my health care provider cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse or revoke this Authorization at any time. I understand that this authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to my health care provider. The revocation will be effective immediately upon my health care providers receipt of my written notice. I have acknowledged that I have received the provider's Inc Notice of Privacy Practices which may be provided at my request. For Medicare Billing: I authorize this provider to release information and request payment. I understand that the information given by me in applying for payment is correct. I authorize the release of all records to act on this request and I request that payment of benefits be made on my behalf. My signature below attests that I have received the COVID-19 Vaccination on the date indicated below by the vaccine administrator.

Signature of patient, representative (power of attorney) or guardian: _______________ Date:__________

****I attest (INITIAL_____)that my reason for receiving the COVID vaccine is truthful and accurate according to all state/federal guidelines. My reason for receiving the vaccine is (circle one):**
AGE, HEALTHCARE PROFESSIONAL, OTHER PROFESSION (CLARIFY IN BOX), CAREGIVER (LIST DEPENDENT NAME AND DOB IN BOX), OTHER (PLEASE LIST DETAILS IN BOX)

(Shaded area below is to be completed by Vaccine Administrator)

Date of Vaccine administration; VIS Given	VIS or EUA Fact Sheet Date (circle one)	Clinical Site Baldwin Homer	County Code	NCES #

Vaccine Given: ☐ Pfizer 1st dose ☐ Pfizer 2nd dose ☐ Moderna 1st dose ☐ Moderna 2nd dose

Manufacturer Inventory Used: Baldwin Homer	Lot Number	NDC #	Expiration Date	Site of Injection: LA RA	Route IM

Pharmacist Signature	Date