COVID-19 IMMUNIZATION SCREENING AND CONSENT FORM

PATIENT INFORMATION

Please Print Clearly

Last Name	First Name	M.I.	D.O.B.

Race/Ethnicity: American Indian/Alaska Native Black/African American Hispanic/Latino
Native Hawaiian/Other Pacific Islander White Asian Other

Street Address		Phone	
City	State	Zip Code	County
Primary Care Physician (PCP) Name *(IF NONE, LEAVE "PCP" FIELDS BLANK)*		PCP Address	
PCP Phone		PCP Fax	

PLEASE ATTACH A COPY OF PATIENT'S INSURANCE CARD - FRONT AND BACK

Are you the primary cardholder? Yes / No

Medicare Recipients
Medicare Number

Medicaid Recipients
Medicaid Number

What dose of COVID-19 Vaccine are you receiving today? 1st 2nd

**Pharmacist: check vaccination card for 1st dose manufacturer, if applicable*

SCREENING QUESTIONNAIRE

The following questions will help us determine your eligibility to be vaccinated today

COVID-19 Vaccine Screening Questions	*Yes*	*No*	*Don't Know*
Are you feeling sick today?			
Have you ever received a dose of COVID-19 Vaccine?			
If "yes," which vaccine product did you receive? (circle) Pfizer Moderna Other			
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 the COVID-19 vaccine			
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.*			
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.*			
Have you received any vaccine in the last 14 days?			
Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19?			
Do you have a bleeding disorder or are you taking a blood thinner?			
Are you pregnant or breast feeding?			

Patient temperature obtained by pharmacist:			Date:
Patient Name (*parent/guardian if minor*):			
Patient Signature (*parent/guardian if minor*):			Date
Mother's Maiden Name *For Minors Only*	Guardian Relationship *For Minors Only*	Guardian Full Name *For Minors Only*	
Administering Pharmacist Intern Signature:			
Supervising Pharmacist Signature:			
Administration Date:			
Date Fact sheet was given to patient:			

I certify that I am: (a) the patient and at least 18 years of age or (b) the parent or legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of

Tracy's Medicine Center, to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements/ Vaccine Fact Sheet(s) on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. I acknowledge that, depending upon my state's law, I may prevent the disclosure of my immunization information by the applicable Provider to the State Registry by using the opt-out form. The Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by

my state's law, by signing below, I hereby do consent to the Provider reporting my immunization information to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information as required or permitted by law. I voluntarily authorize and direct my healthcare provider at Tracy's Medicine Center 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 at Tracy's Medicine Center, my Primary Care Physician, my insurance and/or state or federal registries, where required, for the purpose of treatment, payment or other healthcare operations. I further agree to be fully financially responsible for any cost sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service.

TO BE FILLED OUT BY THE PHARMACY

Vaccine		Manufacturer	
Admin Date		Lot #	
Administration Site	Administration Route	Exp. Date	Volume