Gateway Pharmacy

(First Name) (MI) (Last Name)
(PLEASE PRINT)

Street_____

City_____State_____Zip_____

Phone(____)_____Male ☐ Female ☐

Birth date_____(mm/dd/yy) Age_____
Month Date Year

State where you were born_____

Country where you were born if not USA _____

Race: ☐ American Indian/Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian/Other Pacific Island
☐ White
☐ Other

Ethnicity: ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Allergies:_____

Physician:_____

Primary Insurance_____ID#_____

Cardholder's Birth date_____RxBIN:_____ RxPCN:_____RxGRP: _____

The following questions will help us determine which vaccines may be given to you today. Please check the appropriate answer. If any question is not clear, please ask us to explain it. If you answer "yes" to any question, it does not mean you should not be vaccinated, it just means additional questions may be asked

	Yes	No	Don't know
1. Are you sick today or do you currently have a fever or infection?			
2. Have you ever received a dose of COVID-19 vaccine? • If yes, which vaccine product ☐ Pfizer ☐ Moderna ☐ Another product_____			
3. Have you ever had a serious reaction (ex: anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or had to go to the hospital?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or injected medication?			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. For women; Are you pregnant or breastfeeding?			
9. Do you have a bleeding disorder or are you taking a blood thinner?			

I certify that I am at least 18 years old and hereby give my consent to the staff of Gateway Pharmacy to administer the vaccine listed below. I have read, or have had read to me, the information regarding the vaccine marked below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I, on behalf of myself, my heirs, executors, personal representatives, agents, successors and assigns hereby agree to release, indemnify and hold harmless Gateway Pharmacy, LLC., its agents, offices, 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 vaccines listed below. **This immunization is required be entered into the statewide immunization registry.**

I agree to wait near the vaccination location approximately 20 minutes for observation by a pharmacist.

Signature_____ Date: _____

For office use only:

(X)	Vaccine name / mfg:	Lot#/Exp Date	Dose:	Administration Route: (Please Circle R or L)	Administered by: (staff Initials)
	COVID-19/Moderna		0.5ML	IM R / L	
	COVID-19/Pfizer		0.3ML	IM R / L	
	COVID-19/Janssen		0.5ML	IM R / L	

☐ EUA COVID-19 given to patient ☐ Vaccination card given or filled out (if 2nd dose)

(R.03/08/2021)

☐ intake form verified by RPh_____(initial)