COVID-19 IMMUNIZATION CONSENT FORM

Clinic Provider: Hyde Pharmacy Inc - 1001 W. Kingshighway, Paragould, AR 72450

Legal First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ /_____ /_____ SSN: _____-_____-_____

1. Medical History: Complete the following questions for the individual receiving the vaccine.

*If yes, refer to Pfizer website at www.PfizerMedInfo.com or call 1-800-438-1985. Refer to Pre-vaccination Checklist for COVID-19 Vaccines Information for Healthcare Professionals (cdc.gov) to clarify further questions.	Yes*	No
Have you had a previous COVID-19 vaccination? If yes, date?		
Have you received any vaccinations in the past 14 days?		
Do you have a fever or feel sick today? Do you have COVID-19 or are in quarantine for known exposure?		
Have you previously had COVID-19?		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Vaccination should be deferred for at least 90 days.		
Have you ever had a severe allergic reaction (anaphylactic reaction that required treatment at a hospital or use of an EpiPen) to any vaccine, vaccine component (including polyethylene glycol - PEG), or immediate allergic reaction of any severity to polysorbate, coated tablets, IV steroids, or injectable therapy?		
Have you ever had a severe allergic reaction to any food, oral medication, bee/wasp venom, etc?		
Do you have dermal fillers? If swelling occurs, contact your healthcare provider.		
Do you have a bleeding disorder or are you taking a blood thinner?		
Are you pregnant, breastfeeding, or plan to become pregnant? Women in this group may receive COVID-19 vaccine, a discussion with your healthcare provider can help you make an informed decision.		
Are you immunocompromised? Do you have a condition that weakens your immune system? Are you receiving any immunosuppressive therapy?		
If < 18 years of age: Have you had a well child visit in the last 12 months?		
Note: A second dose of COVID-19 vaccine is due 21 days after initial vaccine. Refer to your vaccine card for second dose due date. Keep your vaccination record card for your records as proof of vaccination.		

Release and Assignment:
Please read the section on the reverse of this form. The Provider's Privacy Notice is available at the clinic site or accompanies this form.

My signature below indicates that I have read, understand, and agree to Release and Assignment of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet.

Signature of Patient/Guardian:

_____ Date: _____

RELEASE AND ASSIGNMENT:

- I have read or had explained to me the Vaccine Recipient Emergency Use Authorization Fact sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient Emergency Use Authorization for each vaccine, visit the website www.cvdvaccine.com to view current EUA.
- I give consent to this COVID-19 provider/staff for the individual named to be vaccinated with COVID-19 vaccine.
- I hereby acknowledge that I have reviewed a copy of the Provider's Privacy Notice.
- I understand that information about this COVID-19 vaccination will be included in WebIZ Arkansas Immunization Information Systems.
- <18 years of age - I have received information regarding well child visits.

To my insurance carrier(s):
I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to this provider. I agree that the authorization will cover all medical services rendered until I revoke the authorization. I agree that the photocopy of this form may be used instead of the original.

PATIENT INFORMATION:

First Name: _____ **MI:** _____ **Last Name:** _____

Date of Birth: _____ / _____ / _____ **Phone Number:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____

Race (check one): ___White ___Hispanic/Latino ___Black/African American ___Asian ___Native American/Alaska Native ___Native Hawaiian/Pacific Islander ___Other

Gender (check one): ___Male ___Female

INSURANCE INFORMATION: check appropriate box

☐ Medicaid/ARKids Number: _____

☐ Medicare Number: _____

☐ Private Insurance

Insurance Company Name: _____

ID number: _____

BIN: _____ RXGroup: _____ RXPCN: _____

FOR STAFF USE ONLY: Pfizer-BioNTech Ultra Cold COVID-19 Vaccine

Route	Dosage	Site	Series	Lot Number	Expiration Date	Reported
IM	0.3 mL	LA / RA	1st / 2nd			____Flat file ____ Billed

Signature and Title of Vaccine Administrator: _____

Date Vaccine Administered: _____ / _____ / _____