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: _____ /_____ /_____

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

*If yes, refer to Pfizer website at www.PfizerMedInfo.com or Moderna website at www.modernatx.com. 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, circle one: Pfizer / Moderna / J&J		
Do you have a fever or feel sick today? Do you have COVID-19 or are in quarantine for known exposure?		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Have you had MIS? (multi system inflammatory syndrome) Vaccination should be deferred for at least 90 days.		
Have you ever had an allergic reaction to a COVID-19 vaccine or to a COVID-19 vaccine component? (including polyethylene glycol - PEG found in colon preps, laxatives, and some medications or to polysorbate which is found in some vaccines, coated tablets, and IV steroids)		
Have you ever had an immediate allergic reaction of any severity to any vaccine or injectable therapy? (Reaction requiring EpiPen, hospitalization, or a serious reaction within 4 hours)		
Have you ever had a severe allergic reaction (anaphylaxis) to any food, pets, venom, environmental, or oral medications?		
Did you develop myocarditis or pericarditis after the first dose of COVID-19 vaccine? Do you have a history or either condition prior to COVID-19 vaccination? Are you a male between the ages of 12 through 29 years?		
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 may be due 21 or 28 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 (or Guardian if < 18):

_____ 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.

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

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

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone Number:** _____

Race: ___White ___Black/African American ___Asian __Native American/Alaska Native

__Native Hawaiian/Pacific Islander __Other

Ethnicity: ___Hispanic/Latino ___Non-Hispanic

Gender: ____Male ____Female

INSURANCE INFORMATION: check appropriate box

☐ Medicaid/ARKids Number: _____

☐ Medicare Number: _____

☐ Private Insurance:

Insurance Company Name: _____

ID number: _____

RX BIN: _____ RX Group: _____ RX PCN: _____

FOR STAFF USE ONLY:

Brand	Route	Dosage	Site	Series	Lot Number	Expiration	Reported
Pfizer	IM	0.3 mL	LA / RA	1st / 2nd / 3rd IC Booster: 3rd			____Flat file ____ Billed
Pfizer Ped		0.2 mL					
Moderna		0.25 mL / 0.5 mL					

Signature and Title of Vaccine Administrator: _____

Date Vaccine Administered: _____ / _____ / _____