COVID-19 VACCINE IMMUNIZATION CONSENT FORM

For COVID-19 Provider use only Clinic Name/Code: _Arch Street Pharmacy__
Location type:(clinic, health department, pharmacy, etc.,) _Pharmacy____
Address: _11200 Arch St_City:_Little Rock___ County: __Pulaski__
State:_Arkansas__ Zip Code: _72206_ Date of Service: _____

Person Receiving Vaccine:

(Legal) First Name: _____ MI: ____ Last Name: _____

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

1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. If you answer "YES" you may not be able to receive the COVID-19 vaccine.

	*YES	NO
Have you had a previous COVID-19 vaccine? If yes, date?		
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?		
Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component or injectable therapy? Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness.		
Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive COVID-19 vaccine, a discussion with your healthcare provider can help make informed decision.		
Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe obesity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive COVID-19 vaccine unless otherwise contraindicated.		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Vaccination should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced immune responses.		

2. **RELEASE AND ASSIGNMENT.**
Please read the section on the next page.
Then sign in the box at right.

Please sign here

My signature below indicates I have read, understand and agree to section **2. Release and Assignment** of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).

Signature of Patient/Parent/Guardian:

_____Date_____

RELEASE AND ASSIGNMENT:

- **I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient Emergency Use Authorization Fact Sheet for each vaccine visit the website www.cvdvaccine.com to view current EUA: or you may also visit the Local Health Unit or private provider to receive a printed copy of the EUA Fact Sheet.**
- **I give consent to this COVID-19 provider/staff for the individual named below to be vaccinated with COVID-19 vaccine.**
- **I understand that information about this COVID-19 vaccination will be included in (WebIZ) Arkansas Immunization Information System.**

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 COVID-19 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:

(Legal) First Name: _____ **MI:** ____ **Last Name:** _____

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ **Gender:** Male Female **Phone #:** _____

Street Address: _____ **P.O. Box** _____ **Apt. No.** _____

City: _____ **State:** _____ **Zip Code:** ☐☐☐☐☐

Race: White Hispanic/Latino Black/African American

Native American /Alaska Native Asian Native Hawaiian/Other Pacific Islander Other

INSURANCE STATUS (Circle): YES or NO. <u>If yes,</u> please provide card/cards to pharmacy.

Last 4 of Social Security #: ☐☐☐☐

COVID-19 VACCINE ADMINISTRATION (Completed by staff only)

Refer to product-specific Emergency Use Authorization (EUA) fact sheet for COVID-19 providers

<u>Frozen COVID-19 Vaccine</u>
Moderna

Route	Site Code	Dosage mL	MFG Code	Lot Number
IM				

<u>MFG Codes:</u> PFR=Pfizer, MOD=Moderna, ASZ=AstraZeneca, JSN=Janssen, NVX=Novavax, MSD=Merck
<u>Site Codes</u>: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA

Signature and Title of Vaccine Administrator: _____

Date Vaccine Administered: _____/_____/_____