COVID-19 SPIKEVAX Consent Form and Record

Must be 65 years of age or older OR 12-64 and at increased risk of severe COVID-19
Must remain in pharmacy for 15 minutes after injection

Aston Pharmacy Home Health Center
"Where caring is the heart of our business"

PERSONAL INFORMATION

01/31/25 Vaccine Information Statement

Please scan and read

Paper copies available upon request

PATIENT NAME:

DATE OF BIRTH: Phone#

ADDRESS:

Primary Physician:

Office Location:

ALLERGIES/MEDICAL ALERT:

SCREENING QUESTIONS:

1.	Are you 65 years or older? If yes, skip to Q 5	☐ YES ☐ NO
2.	Are you between 12 and 64 years of age and wish to receive a COVID-19 vaccine?	☐ YES ☐ NO
3.	Do you have an underlying Medical Condition(s) that increases your risk of severe COVID-19? • If yes, turn form over and complete the questionnaire. You may qualify for the vaccine. • If no, you do not qualify under this protocol. If you choose, see your PCP to discuss the appropriateness of being vaccinated. We may vaccinate you with a prescription.	☐ YES ☐ NO
4.	If you are < 18 years old, is your parent or guardian present or available by phone to get consent?	☐ YES ☐ NO
5.	Have you ever had a reaction after receiving a vaccination, including fainting, or feeling dizzy?	☐ YES ☐ NO
6.	Have you had COVID in the last 3 months? If YES, you may delay your next vaccine by up to 3 months from the start of symptoms or positive test.	☐ YES ☐ NO
7.	Have you ever had an allergic or severe allergic reaction (eg. Anaphylaxis) that required treatment with EpiPen or caused you to go to the hospital OR occurred within 4 hrs of vaccination & caused hives, swelling or respiratory distress/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 OR Polysorbate	☐ YES ☐ NO
	• A previous dose of COVID-19 vaccine or another vaccine?	☐ YES ☐ NO
8.	Have you had myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining outside the heart)?	☐ YES ☐ NO
9.	Do you have a bleeding disorder or are you taking a blood thinner?	☐ YES ☐ NO
10.	Are you considered immunocompromised?	☐ YES ☐ NO
11.	FEMALES: Are you pregnant or breastfeeding?	☐ YES ☐ NO

I have received, read or had the CDC Vaccine Information Statement (VIS) explained to me. I currently have no further questions. I understand the risks and benefits of the vaccine and consent to emergency treatment if needed. I request and voluntarily consent to receive the influenza vaccine, and I acknowledge that no guarantee has been made concerning the vaccine's success. I authorize the release of medical or other information necessary to process insurance claims or for public health purposes.

Patient Signature: Date:

Vaccine	*Manufacturer*	*VIS*	*Lot#*	*Exp Date*	*Site/Route*	*Dosage Vol*
SpikeVax 2025-2026	Moderna	01/31/2025			LD IM RD IM	0.5 mL

Immunizer Signature: Admin Date:

____ Billed ____ Scanned _____ Faxed PCP ____ PIERS updated 9/5/25

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Please review the list of CDC 2025 List of Underlying Medical Conditions That Increase a Person's Risk of Severe COVID-19. Circle any condition you have, read the disclosure statement at the bottom, and sign.

	Asthma		Disabilities, including Down's syndrome
	Blood Cancers		Heart conditions (heart failure, coronary artery disease, or cardiomyopathies)
	Cerebrovascular disease		HIV (human immunodeficiency virus)
	Chronic Kidney Disease - those receiving dialysis		Mental Health conditions: ONLY - Mood disorders, including depression - Schizophrenia spectrum disorders
	Chronic lung diseases: ONLY - Bronchiectasis - COPD - Interstitial lung disease - Pulmonary embolism - Pulmonary hypertension		Neurologic conditions: ONLY - dementia - Parkinson's disease
			Obestiy - BMI >29 kg/m2 or - >94th percentile in children
	Chronis Liver Diseases: ONLY - Cirrhosis - Nonalcoholic fatty liver disease - Alcoholic liver disease - Autoimmune hepatitis		Physical Inactivity
			Pregnancy and recent pregnancy
			Primary immunodeficiencies
	Cystic fibrosis		Smoking, current or former
	Diabetes Mellitus, type 1		Solid-organ or blood stem-cell transplantation
	Diabetes Mellitus, type 2		Tuberculosis
	Gestational Diabetes		Use of corticosteroids or other immunosuppressive medications

I have reviewed the above **CDC 2025 List of Underlying Medical Conditions That Increase a Person's Risk of Severe COVID-19** and indicated that I qualify for the 2025-2026 COVID-19 vaccine based on having the condition(s) that I circled above. I authorize the release of medical or other information necessary to process insurance claims or for public health purposes.

Signature: _____ Date: _____