COVID-19 SPIKEVAX Consent Form and Record

Must be 12 years of age or older

Must remain in pharmacy for 15 minutes after injection

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

PERSONAL INFORMATION

PATIENT NAME:

DATE OF BIRTH: Phone#

ADDRESS:

Email:

Primary Care Physician:

ALLERGIES/MEDICAL ALERT:

SCREENING QUESTIONS:

1.	Are you feeling sick today?	☐ YES ☐ NO
2.	Are you at least 12 years of age?	☐ YES ☐ NO
3.	Have you ever had a reaction after receiving a vaccination, including fainting, or feeling dizzy?	☐ YES ☐ NO
4.	Have you received a dose of any COVID-19 vaccine WITHIN THE LAST 2 MONTHS? If YES, please wait until it has been at least 2 months since your last dose to get this vaccination.	☐ YES ☐ NO
5.	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 sx or positive test.	☐ YES ☐ NO
6.	Have you ever had an allergic reaction to: (includes a severe allergic reaction (eg. Anaphylaxis) that required treatment with EpiPen or caused you to go to the hospital OR occurred within 4 hrs and 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
7.	Have you ever had a severe allergic reaction (eg. Anaphylaxis) to something else, such as food, pet, environmental, or oral medication allergies.	☐ YES ☐ NO
8.	Have you received any vaccine within the last 14 days?	☐ YES ☐ NO
9.	Have you had myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining outside the heart)?	☐ YES ☐ NO
10.	Do you have a bleeding disorder or are you taking a blood thinner?	☐ YES ☐ NO
11.	Are you considered immunocompromised?	☐ YES ☐ NO
12.	FEMALES: Are you pregnant or breastfeeding?	☐ YES ☐ NO

I have been given the Fact Sheet for Recipients &Caregivers and HIPAA. I have read these documents and have no further questions. I understand the risks & benefits & voluntarily consent to receiving the COVID-19 vaccine. I acknowledge that no guarantees have been made concerning the vaccine's success. I understand the possible side effects & precautions that should be considered prior to getting the vaccine and consent to emergency treatment if needed.

Patient Signature: Date:

Vaccine	*Manufacturer*	*VIS*	*Lot#*	*Exp Date*	*Site/Route*	*Dosage Vol*
SpikeVax 2023-2024	Moderna	10/19/23	**3030948**	**4/8/2024**	LD IM RD IM	0.5 mL

Immunizer Signature: Admin Date:

____ Billed ____ Scanned _____ Faxed PCP ____ PA SIIS