COVID 19 VACCINE ADMINISTRATION CONSENT FORM (v8.2024)

Circle Vaccine Requested: Pfizer - Moderna - Novavax

VACCINE RECIPIENT INFORMATION

First Name:_____ **Last Name:**_____ **Gender:** ☐ *Female* ☐ *Male*

Date of Birth:_____ **Age:**_____ **Phone:**_____

Home Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Drug allergies:_____

Please provide your ID and insurance and any supplement cards-both prescription and medical.

If you don't have your card, please provide your SS # _____-_____-_____.

Medicare B patients please provide alpha-numeric # _____-_____-_____

These questions help determine eligibility for vaccination	**YES**	**NO**
1. Is the vaccine recipient sick today (have a fever, an infection, diarrhea, shortness of breath, aches, loss of taste or smell, or vomiting today) ?		
2. Has the vaccine recipient ever received a Covid-19 Vaccine? If yes, list vaccine name here and date of last dose: _____ _____/_____/_____		
3. Has the vaccine recipient ever had a severe reaction to any vaccine or injectable which required use of EpiPen, medical care or Hospitalization? Allergy to Polyethylene glycol (PEG), polysorbate, or previous dose of Covid-19 vaccine?		
4. Has the vaccine recipient been exposed to anyone positive OR suspected positive for COVID 19 in the last 14 days?		
5. Does the vaccine recipient have a history of myocarditis or pericarditis?		
6. Would you like your vaccine administration reported to the Texas Immunization Registry?		

Check all that apply to the vaccine recipient:

☐ Have a history of Covid 19 disease in the past 3 months

☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after Covid 19 infection

☐ Pregnant or Breastfeeding ☐ Take a blood thinner (i.e. aspirin, warfarin, etc)

☐ Have a history of Heparin induced thrombocytopenia (HIT) ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)

☐ Have a weakened immune system caused by something such as HIV/AIDS or cancer or take immunosuppressive drugs or therapies ☐ History of Guillain-Barre Syndrome (GBS)

☐ Received a previous Covid 19 vaccine before or during hematopoietic cell transplant or CAR-T cell therapies

☐ Have had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pets, venom, environmental or oral medications

NOTE: Answering yes to any of questions may warrant referral to a physician for further evaluation to determine appropriateness of the vaccination

CONSENT/AUTHORIZATIONS: I certify that I am: (i) the Patient and at least 18 years of age; (ii) the parent or guardian of the minor Patient; or (iii) the legal guardian of the Patient. Additionally I, the undersigned, hereby certify and attest that I have sought evaluation, treatment, or medical advice from the staff at Liberty Pharmacy the "Facility", including but not limited to licensed and trained pharmacists and/or pharmacy technicians. I understand that these providers may perform services at various locations such as within a mobile or another healthcare setting, i.e., a pharmacy, LTC facility. I understand that it is not possible to predict all possible side effects or complications associated with receiving the covid 19 vaccine. I understand the risks and benefits associated with the below vaccine and have received, read and/or had explained to me the Vaccine Information Statement or EUA Fact Sheet for the covid 19 vaccine I, or my child, have elected to receive and all my questions have been answered to my satisfaction. I additionally acknowledge that I have received a copy of the Facility notice of the privacy practices. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering health care provider. I further authorize the Facility to (1) release my medical records or other information to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment or otherwise, (2) submit a claim to my insurer for the requested items and services, and (3) request payment of authorized benefits be made on my behalf to Liberty Pharmacy with respect to the requested items and services. If my medical insurance coverage is not accepted by the Facility or is not appropriate/covered, I authorize Liberty Pharmacy to bill my prescription insurance for these services instead. I understand that in the course of the requested vaccine administration, an immunizing staff member could possibly be exposed to my blood or bodily fluids. In such event, I agree to review and execute a Post-exposure Consent for Testing form. **WAIVER/INDEMNITY:** On behalf of myself, vaccine recipient, my heirs and personal representatives, I further hereby both WAIVE/RELEASE and AGREE TO INDEMNIFY, DEFEND AND HOLD HARMLESS (including for costs and attorney's fees) any and all healthcare providers of Liberty Pharmacy, its staff, agents, owner and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of services even should such damages or losses result from negligence.

_____ Patient/Parent/Guardian Signature

_____ Relationship to Vaccine recipient if <18yo

_____/_____/_____ Date

VACCINE INFORMATION (Office use only)

Moderna/Pfizer/Novavax		____/____/____	0.3ml 0.5ml	IM	R or L Delt
Vaccine	Lot #	Exp. Date	Dose (ml)	Route	Admin. Site

____/____/____	10/19/2023	MufidN/KunalN/JillianB/HugoB/Brandy W/VanessaG/AdrianaS
Admin. Date	VIS/EUA Date	ADMINISTRATOR