COVID 19 VACCINE ADMINISTRATION CONSENT FORM (v9.2022)

Circle Vaccine: Boosters: BIVALENT Pfizer (>12yo). - BIVALENT Moderna (>18yo)

Routine vaccines: Moderna >18yo (1st 2nd or 3rd) - Pfizer > 12yo (1st 2nd or 3rd) - Novavax > 12yo (1st or 2nd) - Janssen >18yo

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

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

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

County:_____ **Drug allergies:**_____

Race (circle): American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Pacific Islander White Other Unknown Prefer not Disclose

Ethnicity (circle): Latino Not Hispanic or Latino Unknown Prefer not to Disclose

Please provide your ID and insurance card. If you are uninsured or don't have your card, please provide your SS # _____-_____-_____

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

These questions help determine eligibility for different vaccinations	**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 here:_____ and have the vaccine card ready.		
3. Have 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?		

Check all that apply to the vaccine recipient:

☐Female between 18-49 ☐ Male between age 12-29 ☐Have a history of myocarditis or Pericarditis

☐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 and/or Khem Labs LLC , the "Facility", including but not limited to providers Kunal Nagarsheth, Mufid Najjar, or other qualified staff members under the supervision of Dr. Joel Jones. 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 EUA Fact Sheet on the covid 19 vaccine I 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 Khem Labs LLC with respect to the requested items and services. If my medical insurance coverage is not accepted by the Facility or does not cover these services, 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. **I understand that this covid 19 vaccine administration information will be reported to the Texas DHS and CDC as required.**

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 Khem Labs LLC and/or 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 **Date**

_____

Relationship to Vaccine recipient if <18yo

VACCINE INFORMATION (Office use only)

Moderna/Pfizer/Novavax/Janssen	_____	___/___/___	0.3ml 0.5ml	IM	Right or Left Deltoid
Vaccine	Lot #	Exp. Date	Dose (ml).	Route	Admin. Site

___/___/___	Moderna-8.31.22/Janssen-5.5.22/Pfizer-8.31.22/Novavax-7.13.22	MufidN/KunalN/JohnnyA/HugoB/Brandy W/VanessaG/AdrianaS
Admin. Date	EUA Date	ADMINISTRATOR