6635 Falls of Neuse Rd.
Raleigh, NC 27615
Phone 919.676.6161
Fax 919.676.6575

Screening, Consent, & Physician Fax Form: COVID-19

Patient Information: Please complete both the front (top portion only) and back of this form.

*Patient Name__________________________________ *Date of Birth_____________ *Weight ____________

*Address________________________________ *City_____________ *State____ *Zip_______ *Gender M or F

*Phone#_______________________ ☐ Cell ☐ Home *Email____

☐ OUR FREE MOBILE APP OFFERS 2-WAY MESSAGING! CHECK HERE TO RECEIVE A TEXT WITH THE LINK TO DOWNLOAD IT!

*Medical Conditions____

*Primary Insurance__________________________*Medicare Beneficiary ID (if applicable)_________________________

**Have our RxLocal Mobile App? Send us a picture of your insurance card via the app
**You may also TEXT a picture of your insurance card to 919.646.2997

*If uninsured, SSN _________________________*Primary Doctor__________________________________

______________________________________**Stop here and continue on to the BACK of this form →**

Pharmacy Use Only/Physician Notification: Dr. Fax#______________________________

Dear Doctor: Today the above patient was vaccinated at our store. Please retain for your records.

Vaccine	VIS/EUA Date	Date VIS/EUA was Given to Patient
☐ Moderna COVID-19 vaccine (1st dose)	12/2020	_______________
☐ Moderna COVID-19 vaccine (2nd dose / 28 days)	12/2020	_______________
☐ Janssen COVID-19 vaccine (single dose)	3/19/2021	_______________

Vaccine Administrator Name ________________________________Title_____________________

Signature____

Place Rx Label Here

(cover pricing)

DOSE 1

Date & Time Administered___________

☐ Provided patient with Vaccination Record & V-Safe info

Site LA or RA (Circle one)

Lot# _______________

Exp Date____N/A______

DOSE 2 (MODERNA ONLY)

Date & Time Administered___________

☐ Updated Vaccination Record Card

Site LA or RA (Circle one)

Lot# _______________

Exp Date____N/A______

Dose 1 Entered in CVMS by ____________ on ____/____

Dose 2 Entered in CVMS by ____________ on ____/____(Moderna ONLY)

Dose 2 Appt Date/Time (Moderna ONLY) ______________________________

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Screening/Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients: The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. Answering yes to any of the following questions does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your Pharmacist to explain it.

	YES	NO	DON'T KNOW
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 Vaccine? If yes, which vaccine product did you receive? • Pfizer • Moderna • Another Product____________________			
3. Have you ever had an allergic reaction to:			
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			
Polysorbate			
A previous dose of COVID-19 vaccine			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists

Patient Consent

❖ I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid or other payer as needed & request payment of authorized benefits to be made on my behalf to Medicap.

❖ I acknowledge that the Pharmacist recommends that vaccinated patients should remain in the waiting area, after the administration of the vaccine, for 15 minutes (or 30 minutes if I have every had an immediate allergic reaction to a vaccine or injectable therapy or a history of anaphylaxis due to any cause)

❖ Consent: I have read, or have had read to me the EUA and/or CDC Vaccine Information Sheet (VIS) regarding the vaccine. I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine. I consent to, or give consent for, the administration of the vaccine. I fully release and discharge Medicap Pharmacy, its affiliates, their officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from.

❖ I understand the benefits and risks of the vaccination as described in the Emergency Use Authorization (EUA) and/or CDC Vaccine Information Statement (VIS), a copy of which can be found online using the link or QR Code below *or* provided upon request with this Consent and Release. I request the vaccine be given to me or the person named below, a minor for whom I represent and that I am authorized to sign this Consent and Release

Moderna EUA:
http://www.modernatx.com/covid19vaccine-eua

Janssen EUA:
https://www.janssenlabels.com/emergency-use-authorization/Janssen+COVID-19+Vaccine-Recipient-fact-sheet.pdf

Patient Signature ___________________________________ (OR parent/guardian if under 18) **Date**_________

Print Parent/Guardian name if recipient is a minor: ___________________________________

Form reviewed by: ___________________________, Pharmacist/Immunizer

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