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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

*Occupation (age <65) _____ *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
<input type="checkbox"/> Moderna COVID-19 vaccine (1 st dose)	12/2020	_____
<input type="checkbox"/> Moderna COVID-19 vaccine (2 nd dose / 28 days)	12/2020	_____

Vaccine Name _____, Pharmacist

Administrator

Signature _____

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 1 Entered in CVMS by _____ on ____/____

Dose 2 Entered in CVMS by _____ on ____/____

Dose 2 Appt Date/Time _____

DOSE 2

Date & Time Administered _____

Updated Vaccination Record Card

Site LA or RA (Circle one)

Lot# _____

Exp Date N/A

Place Rx
Label Here
(cover pricing)

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?			

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 third party payer as needed and 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 at <http://www.modernatx.com/covid19vaccine-eua> 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.

The EUA for the Moderna COVID 19 Vaccine can be found by scanning this QR Code, or by visiting <http://www.modernatx.com/covid19vaccine-eua>



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

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

Form reviewed by: _____, Pharmacist

The documents accompanying this facsimile contain confidential health information that is legally privileged and protected by HIPAA. This facsimile is intended solely for the authorized recipient named above. If you have received this facsimile in error, please notify the sender immediately to arrange for the prompt return or destruction of all documents. Absolutely no action should be taken to copy, distribute or further disclose any documents to a third party at any time. Rev. 03/18