**COVID-19 Immunization: Medicap Pharmacy/Medicus Urgent Care/VNA Hospice**

Name: _____Gender: M F O **DATE:** _____

Address: _____ Date of Birth: _____

Phone: _____E-mail_____

**Ethnicity/Race** : □ Arabian; □Asian Indian; □Black; □Chinese; □Filipino; □Indian; □Japanese; □Korean; □Thailander; □Vietnamese; □ White; □Cuban; □Mexican; □Puerto Rican; □South or Central American; □Unknown □Prefer not to Answer; □Other: _____
□ Hispanic; □Non-Hispanic;

**Eligibility:** □ **FIRST OR SECOND DOSE** □ **IMMUNOCOMPRIMISED** □ **BOOSTER**

## Screening Questionnaire for Immunization:

| | | | |
|---|---|---|---|
| **1** | Are you sick today? | Yes | No |
| **2** | In the past 2 weeks have you tested positive for COVID-19 or has your doctor ever told you that you had COVID-19? Date of Positive test: _____ | Yes | No |
| **3** | Have you received any other vaccine in the past 14 days? Which one? _____ | Yes | No |
| **4** | Have you received COVID-19 Monoclonal antibodies or convalescent serum in the past 90 days? | Yes | No |
| **5** | Do you have any allergies to these components of the COVID 19 vaccine? polyethylene glycol or polysorbate | Yes | No |
| **6** | Do you have any vaccine, drug or food allergies that caused anaphylaxis which required an epi-pen or hospitalization? | Yes | No |
| **7** | Have you ever fainted after receiving a vaccine? | Yes | No |
| **8** | Do you have a bleeding disorder or are taking a blood thinner (Aspirin, Warfarin, Coumadin, Eliquis, Xarelto etc)? | Yes | No |
| **9** | Are you taking immunosuppressive drugs or have a weaken immune system (eg: HIV infection, cancer, etc. ) | Yes | No |
| **10** | Do you have dermal fillers? | Yes | No |
| **11** | Are you pregnant or breastfeeding? | Yes | No N/A |
| | **ONLY If this is your SECOND VACCINE- PLEASE Answer the questions BELOW :** | | |
| **12** | Are there any changes to the responses to questions 1 – 12? | Yes | No N/A |
| **13** | Did you experience anaphylaxis after a previous dose of the COVID-19 vaccine? | Yes | No N/A |
| **14** | Did you experience any of the following within 4 hours after receiving a previous dose of the COVID-19 vaccine: *anaphylaxis, hives, angioedema, or respiratory distress (eg: wheezing, )*? | Yes | No N/A |

## Vaccine Consent Form

**Print Name:** _____. I have been given the FACT SHEET FOR RECIPIENTS AND CAREGIVERS understand the FDA has authorized the emergency use of the COVID-19 vaccine, which is not an FDA approved vaccine. I understand the benefits and risks of the vaccine. I understand that I may refuse vaccination.
I have had the opportunity to ask questions about the vaccine and my questions have been answered to my satisfaction. I understand the known benefits and risks of the vaccine and understand that some risks may not be known. I authorize information about my vaccine administration and any vaccine reactions to be submitted to the Department of Health. I agree to stay onsite 15 minutes after receiving my vaccination. I understand that if I experience any side effects, I am responsible for following up with my physician at my expense.
On behalf of myself, heirs, and my personal representatives, I hereby release the providers administering the vaccine and Medicap Pharmacy/Medicus Urgent Care/VNA Hospice and their owners, operators, directors, administrations, employees, and agents from any liability that may arise from this vaccine. **Under these terms, I consent to receive the required doses of Moderna or Pfizer COVID-19 Vaccine and to authorize the provider to bill my insurance for the immunization administration only:**

**Sign here:**_____ **Date:**_____

**Parent Consent:**_____ **Date:**_____

Primary Insurance: _____ **ID**: _____ **Group:** _____ **BIN**: _____ **PCN**: _____

**Provider USE Only Date of Administration:** ☐ **First Dose** ☐**Second Dose** ☐**THIRD DOSE**

**Moderna COVID-19 vaccine lot number:** _____ **Dose 0.5 ml** **Exp. date:** _____ **EUA Date 12/20/20**

**Pfizer COVID-19 vaccine lot number:** _____ **Dose 0.3 ml** **Exp. Date:** _____ **EUA Date 12/11/20**

**Intramuscular** **Injection Site:** □**RD** □**LD**

**Providers/Vaccinator Name:**_____ **Signature:**_____