Pharm A Save Monroe
17788 147th ST SE
Monroe, WA 98272

Vaccine Consent Form ***w/ Covid 19 Checklist***

Clinic Yes__No _

Patient Information (Please fill out completely) **Today's Date:**_____

Name:_____**Date of Birth:**_____**Phone #**_____

Parent or Guardian:_____**Email:** _____

Address: _____

City:_____**State:**_____**Zip**_____

Patient Race: (Please check)

__ White __ Asian __ Black or African American __ Native Hawaiian or Pacific Islander __ American Indian or Native Alaskan

Patient Ethnicity (Please Check) __ Non-Hispanic __ Hispanic

Primary Care provider: _____**Allergies:**_____

Which Dose #: _____**Medical Reason if 3rd dose:**_____

Prior Vaccine Given (Moderna or Pfizer or J&J): _____

"I have read or have had explained to me the information in the CDC vaccine information statement(s). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of this/these vaccines and ask that the vaccine(s) be given to me"_____

******************************Pharmacy use only*******************************

Vaccines Administered

__Influenza Injectable	**__Shingrix**	**__Varicella**
__Influenza Nasal	**__MMR**	**__Prevnar 13**
__Pneumovax 23	**__Twinrix (Hep A and B)**	**__IPV**
__Hepatitis A	**__Tdap**	**__Meningococcal**
__Hepatitis B	**__Oral Typhoid**	**__Hib**
__ Moderna 18+	**__ Pfizer BioNTech**	**__ J&J Vaccine**
Other _____		

LOT # _____
EXPIRATION:_____
ADMIN SITE: LA or RA

LOT # _____
EXPIRATION:_____
ADMIN SITE: LA or RA

LOT # _____
EXPIRATION:_____
ADMIN SITE: LA or RA

Pharmacist:_____License #_____NPI: _____

Substitution Permitted_____Dispense AS Written _____

*Signature of pharmacist who administered the vaccine and provided VIS to patient and Date _____

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Name _____

Age _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes"to any question, it 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 healthcare provider 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 ____Janssen (Johnson &Johnson) ___ Another product _____			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen• or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of a COVID-19 vaccine including either of the following:			
o Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
o Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
• A previous dose of COVID-19 vaccine.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen• orthat caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication?This would include food, pet, venom, 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. Do you have a history of or a risk factor for a blood clotting disorder?			
12. Are you pregnant or breastfeeding?			
13. Do you have dermal fillers?			

Form reviewed by _____ **Date** _____

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