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412-323-1801

WALTMIRE PHARMACY

Blue Cross
Aetna
Gateway
Geisinger
Humana

Medicare
UPMC
United HC
PA H&W
_____

COVID-19Immunization Consent Form

Section 1: Information about Patient to Receive

COVID-19 Vaccine *(please print)* *ALL FIELDS REQUIRED

PATIENT'S NAME (Last)	(First)	**DATE OF BIRTH** Month_____ Day_____ Year____	
ADDRESS		**AGE**	**GENDER** M F
CITY		**STATE**	**ZIP**
ETHNICITY (please circle) Asian Hispanic/Latino Other Black/African American White	**PHONE NUMBER**	**EMAIL**	

Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if you are eligible to receive the COVID-19 vaccine today.
Please check YES or NO for each question. **Dose 3**

	YES	NO		
Are you feeling sick today?				
Have you ever received a dose of any COVID-19 vaccine? - If yes, which product? Pfizer Moderna Other_____				
Do you have any allergies to medications, food, latex, or vaccine components? - If yes, please specify _____				

Have you ever had a severe allergic reaction (i.e. anaphylaxis)? For example, a reaction for which you were treated with an EpiPen (epinephrine) or for which you had to go to a hospital?
- If yes, was the severe allergic reaction from --
  - A previous COVID-19 vaccine?
  - Another vaccine, injectable medication, or shellfish?				

Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?				
Have you received another vaccine in the last 14 days?				
Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?				
Do you have a weakened immune system caused by something such as HIV infection, cancer, or immunosuppressive medications or therapies?				
Do you have a bleeding disorder or are you taking a blood thinner?				
Are you pregnant or breastfeeding?				

Patient Signature (Dose 3)_____ **Date:**___/___/___

Screening Questions reviewed by:_____

Section 3: Patient Consent *(please read this section in its entirety)*

I have read or have explained to me the current Vaccine Information State (EUA) for the COVID-19 vaccine and understand the risks and benefits.

I DO GIVE CONSENT -- By signing below, I give consent to Waltmire Pharmacy (Momba Pharmacy Services LLC) and its staff, to vaccinate myself with the COVID-19 vaccine series, dose 1 followed 28 days later by dose 2, and to report any data collected on this form to the required State and/or Federal agencies as required (if this consent form is not signed, then the patient will not be vaccinated).

I also agree to hold harmless Waltmire Pharmacy, its directors, officers, employees, agents, and stockholders from and against all claims, demands, actions, suits, damages, liabilities, losses, settlements, judgments, costs, and expenses (including but not limited to reasonable attorney fees and costs), whether or not involving a third-party claim, which may arise out of, or relate to, the administration of this vaccine.

Patient Signature (Dose 3)_____ **Date:**___/___/___

Section 4: Insurance Information

Please fill out this section if not providing insurance card

Prescription Insurance Information

Insurer:_____

ID #:_____

RX Group:_____

RX BIN:_____

RX PCN:_____

Medical Insurance Information

Insurer:_____

ID #:_____

Group:_____

Medicare ID*:_____

*Requires Red, White, and Blue Card

Pharmacy Use Only

Section 5: Vaccination Record

Vaccine	Dose	Route (IM): Deltoid	Date of Administration	Manufacturer	Lot / Exp
COVID-19	3	Left Right	___/___/___	Pfizer _____	_____/_____
COVID-19	3	Left Right	___/___/___	Moderna _____	_____/_____

Pharmacist:

Fred DePasquale (NPI :1740575620) Signature:_____ Date:___/___/___

_____NPI :_____ Signature:_____ Date:___/___/___

_____NPI :_____ Signature:_____ Date:___/___/___

_____NPI:_____ Signature:_____ Date:___/___/___

Dose 3

Entered into PA-SIIS

Entered into RX30