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**WALTMIRE
PHARMACY**

Blue Cross Medicare
Aetna UPMC
Gateway United HC
Geisinger PA H&W
Humana

COVID-19 Immunization 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 1		Dose 2	
	YES	NO	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 1) _____

Date: ____ / ____ / ____

Screening Questions reviewed by: _____

Patient Signature (Dose 2) _____

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 1) _____

Date: ___/___/___

Patient Signature (Dose 2) _____

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	1	Left Right	___/___/___	Moderna _____	___/___
COVID-19	2	Left Right	___/___/___	Moderna _____	___/___

Pharmacist:

Fred DePasquale (NPI :1740575620)

NPI : _____

NPI : _____

NPI: _____

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

Dose 1

Entered into PA-SIIS
Entered into RX30

Dose 2

Entered into PA-SIIS
Entered into RX30