

# COVID Vaccine Intake Consent Form

River City Pharmacy  
 2717 Spring Ave. SW  
 Decatur, AL 35603  
 256-445-5400



## Patient Information

First Name	Last Name	Date of Birth	Gender
Address		City	State Zip
Primary Care Provider (PCP) Name	PCP Phone Number	PCP Fax Number	
PCP Address	City	State	Zip

Are you a **resident**  of a Long Term Care facility or an **employee/staff member**  ?

Is this the patient's **first**  or **second**  dose of the COVID-19 vaccination?

**Insurance Information:** (For onsite clinics, please ensure a copy of the patient's insurance card(s) was collected)

\*INDICATES REQUIRED FIELDS

### Prescription Insurance:

<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Are you the primary cardholder?		If no, include the primary cardholder's DOB		
Prescription Benefit Plan Name	Cardholder ID #	RX Group ID	BIN	PCN

### Medicare Fields:

<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the Patient age 65 or older or Medicare Eligible?	Medicare Part A/B ID Number (MBI) Note: MDI is required for all patients age 65 and older, or Medicare eligible. Refer to your Medicare Red, White, and Blue card

### Medical Insurance:

Medical Insurance Provider	Cardholder ID #	Group ID	Payer ID
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Is the patient the primary cardholder?	If no, include primary cardholder's DOB		

**If uninsured, you must check the box below to attest that the following information is true and accurate:**

I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government-funded health benefit plan.

In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, please provide either (a) a valid Social Security number, (b) state identification number and state of issuance, OR (c) a driver's license number and the state of issuance.

Social Security Number	or State Identification Number & State	or Driver's License Number & State
------------------------	--	------------------------------------

Potential Contraindications	Yes	No	Don't Know
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever received a dose of COVID-19 vaccine If yes, which vaccine product? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Another product: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) in the past? Example: a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Was the severe allergic reaction after receiving a COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the severe allergic reaction after receiving another vaccine or injectable medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the severe allergic reaction related to receiving Polyethylene Glycol or products containing Polyethylene Glycol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the severe allergic reaction related to receiving Polysorbate or products containing Polysorbate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you received any vaccines in the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Potential Considerations</b>	<b>Yes</b>	<b>No</b>	<b>Don't Know</b>
6. Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. For women, are you currently pregnant or breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**CONSENT FOR SERVICES:** I have been provided with the Vaccine Information Sheet(s) or patient fact sheet corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

**AUTHORIZATION TO REQUEST PAYMENT:** I do hereby authorize River City Pharmacy (RCP) to release information and request payment. I certify that the information given to me in applying for payment under Medicare or Medicaid, or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on behalf of myself.

**DISCLOSURE OF RECORDS:** I understand that RCP may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at RCP (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that RCP will use and disclose my health information as set forth in the RCP Notice of Privacy Practices (copy is available in-store and by requesting a paper copy from the pharmacy). Vaccine Clinics: If I am receiving a vaccine through a vaccine clinic, I understand that my name, vaccine appointment date and time will be provided to the clinic coordinator.

Signature of patient to receive vaccine (or parent, guardian, or authorized representative)		Date
If signing on behalf of the patient, you are stating that you are authorized to provide the required consents on behalf of the patient.		
Name of parent, guardian, or authorized representative	Phone Number	Relationship

### Vaccine Administration Information for Immunizer/Pharmacist use only

Administration Date	Vaccine	VIS Date	Manufacturer	Volume (mL)
			<input type="checkbox"/> L	<input type="checkbox"/> R
Lot #	Exp. Date	Route	Site	
	If patient's body temperature is 100.4 F or greater, inform them they should not receive the vaccine at this time.			
Patient Temperature				
Administering Immunizer Name & Title			Administering Immunizer Signature	