COVID Vaccine Consent Form

The Vine Health & Wellness
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:

☐ Yes	☐ 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:

☐ Yes ☐ 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

☐ Yes	☐ 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?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Another product: __________	☐	☐	☐
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?	☐	☐	☐
Was the severe allergic reaction after receiving a COVID-19 vaccine?	☐	☐	☐

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

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

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Vaccine Administration Information for Immunizer/Pharmacist use only

	Janseen COVID19	03/19/2021	Janssen Biotech	0.5
Administration Date	Vaccine	VIS Date	Manufacturer	Volume (mL)
		IM	☐ L	☐ R
Lot # 203A21A	Exp. Date 06/23/2021	Route IM	Site Deltoid	
	If patient's body temperature is 100.4 F or greater, inform them they should not receive the vaccine at this time.			

Administering Immunizer Name & Title	Administering Immunizer Signature

VITALS:	BP	HR	TEMP	O2