HARVEST DRUG & GIFT
"...more than just a drug store"

4426 Kell Blvd • Wichita Falls, TX 76309
940.692.7081 • harvestdrug.com

COVID-19 Vaccine Screening, Patient Consent, & Administration Record

Name:_____

Birthdate:_____ **Phone** _____ **Gender (circle one): Male / Female**

Address:_____

City, State, Zip:_____ **Primary Care Physician:** _____

Race: (Circle One): American Indian/Alaska Native - Asian - Black/African-American - Native Hawaiian/Pacific Islander - White - Other

Ethnicity (Circle One): Hispanic/Latino - **Not** Hispanic/Latino

Email:_____

PLEASE READ THE LIST BELOW AND INDICATE YES OR NO FOR THE PERSON RECEIVING VACCINES TODAY

1. ARE YOU YOUNGER THAN 18 YEARS OF AGE? YES NO
2. IN THE PAST 2-14 DAYS HAVE YOU EXPERIENCED FEVER OR CHILLS, COUGH, SHORTNESS OF BREATH, FATIGUE, MUSCLE/ BODY ACHES, HEADACHE, NEW LOSS OF TASTE OR SMELL, SORE THROAT, CONGESTION OR RUNNY NOSE, NAUSEA OR VOMITING, DIARRHEA. YES NO
3. IN THE PAST 2-14 DAYS ARE YOU AWARE OF BEING EXPOSED TO SOMEONE WHO TESTED POSITIVE FOR COVID-19? YES NO

   HAVE YOU RECEIVED ANY OTHER VACCINE (S) IN THE LAST 14 DAYS? YES NO
4. HAVE YOU HAD IMMUNE GLOBULIN OR A BLOOD TRANSFUSION IN THE PAST 90 DAYS (3 MONTHS)? YES NO
5. HAVE YOU PREVIOUSLY TESTED POSITIVE FOR COVID-19? IF SO, WHEN? _____ YES NO
6. HAVE YOU ALREADY HAD THE FIRST DOSE OF A COVID-19 VACCINE? YES NO
7. HAVE YOU EVER HAD A SEVERE REACTION TO ANY VACCINE OR MEDICATION THAT REQUIRED MEDICAL CARE? YES NO
8. ARE YOU PREGNANT OR PLANNING PREGANCY IN THE NEXT THREE (3) MONTHS? YES NO
9. ARE YOU CURRENTLY BREASTFEEDING? YES NO
10. ARE YOU IMMUNOCOMPROMISED OR RECEIVING IMMUNOSUPPRESSANT THERAPY? YES NO
11. ARE YOU A HEALTHCARE WORKER OR AN EMPLOYEE AT A HEALTHCARE FACILITY? YES NO
12. ARE YOU 65 YEARS OF AGE OR OLDER? YES NO
13. LIST ANY DISEASES YOU'VE BEEN DIAGNOSED WITH:

    _____
14. LIST ALL PRESCRIPTIONS AND/OR OVER THE COUNTER MEDICATIONS YOU TAKE ROUTINELY

_____

16. LIST DRUG ALLERGIES_____

Patient Consent: I have read, or have had read to me, the Vaccination Information Statement (VIS) regarding the vaccine I am about to receive. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine. I consent to, or give consent for, the administration of the vaccine and the notification of my primary care physician. I authorize the release of any medical or other information necessary to process this claim. I understand that I should remain in the pharmacy for 15 minutes for observation in case there is an adverse reaction.

Signature: _____ **Date:** _____

FOR OFFICE USE ONLY:

Vaccine	Manufacturer	Lot	Dose (1^{st} or 2^{nd})	Site	Amt/Admin	EUA Date	Administrator
COVID-19	Janssen/J&J		One Dose	RA/LA	0.5 mL IM	12/2021	

Updated 03/19/2021