Providence Community Pharmacy

803 Providence Road, Suite 101 Wayne, NE 68787 402-375-8862

COVID-19 VACCINATION ASSESSMENT & CONSENT FORM

Name: _____ DOB:_____/_____/_____ Age:_____ Gender: M F
(Patient Name)

Address: _____ City:_____ State:_____

Zip:_____ Phone:_____-_____-_____

Physician:_____ Ethnicity/Race:_____

Emergency Contact:_____ Relationship to patient_____ Phone:_____-_____-_____

Mother's First Name: _____ Mother's Maiden Name: _____

	Please check answer	
1. Do you feel sick today?	_____ Yes	_____ No
2. Do you have any allergies to medications, vaccines or need to carry epipen for possible allergic reaction?	_____ Yes	_____ No
3. Have you ever had an allergic reaction to any type of vaccine?	_____ Yes	_____ No
4. Have you received any type of vaccine **within the last 14 days**?	_____ Yes	_____ No
5. Do you have any chronic health conditions i.e. heart disease, COPD, diabetes, etc?	_____ Yes	_____ No
6. Do you have any immune suppressed condition such as cancer treatment, HIV/AIDS, transplant, cochlear implant etc?	_____ Yes	_____ No
7. Have you received convalescent plasma or a monoclonal antibody infusion (i.e. bamlanivimab, regeneron) **within the last 90 days**?	_____ Yes	_____ No
8. Are you pregnant, breast feeding or planning to get pregnant in the next 60 days?	_____ Yes	_____ No
9. Have you ever tested positive for COVID 19?	_____ Yes	_____ No
10. Have you had any of the following symptoms within the last 14 days? If yes, circle the symptoms below: Fever, chills, cough, sputum/phlegm, SOB/trouble breathing, change or loss of taste/smell, fatigue, loss of appetite, headache, sore throat, congestion, nausea, vomiting, diarrhea, muscle/body aches, runny nose	_____ Yes	_____ No

Patient Consent for Immunization

I have read the information or have had the information explained to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of Covid vaccine and ask that the vaccine be given to me, or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination.

Signature:_____ Date: _____

Immunization Personnel Only

SITE: Right Deltoid_____ Left Deltoid_____ Lot #/ Exp Date: _____

Prescribed/Administered by: _____

BIN # _____ PCN _____ ID _____ Group _____