

**COVID-19 Vaccine Consent Form**  
**RX Mart Pharmacy 300 E Sunset Drive, Bellingham, WA 98225**  
**Tel: (360) 933-1401 Fax: (360) 393-3445**

**Section 1: Patient/Employee Information**

NAME (Last)	(First)	DATE OF BIRTH	GENDER
ADDRESS			
CITY	STATE	ZIP	DAYTIME PHONE NUMBER
PRIMARY CARE PHYSICIAN: Name		Address	Phone Number
EMERGENCY CONTACT: Name		Relation	Phone Number

**Section 2: Screening Questions**

	YES	NO
1. Do you have any <b>drug</b> allergies? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you sick today? (For example, cold, fever, or acute illness)	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have a bleeding disorder or are you on a blood thinner?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you immunocompromised or are you on a medicine that affects your immune system?	<input type="checkbox"/>	<input type="checkbox"/>
5. <b>Are you pregnant or plan to become pregnant or breastfeeding?</b>	<input type="checkbox"/>	<input type="checkbox"/>
6. <b>Have you received another COVID-19 vaccine elsewhere? If yes, name of vaccine_</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Current Pharmacy? _____		

**Section 3: Consent**

I have been given a copy and have read, or have had explained to me, the information in the **FACT SHEET** for the COVID-19 vaccine. I understand the FDA has authorized the emergency use of the COVID-19 vaccine, which is not an FDA-approved vaccine. I have had the chance to ask questions that were answered to my satisfaction.

I understand the COVID-19 vaccine requires 2 doses given 4 weeks apart. If this is my first dose of the COVID-19 vaccine, I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the vaccination series.

I understand the significant known and potential risks and benefits of the COVID-19 vaccine as explained in the FACT SHEET and that some potential risks and benefits may remain unknown, and **I REQUEST THE COVID-19 VACCINE BE GIVEN TO ME.**

I agree to stay in the vaccine administration area for fifteen (15) minutes (or longer if indicated by the vaccine administrator) after receiving my vaccination to ensure that no immediate adverse reactions occur, and I understand that if I experience any adverse reaction, it will be my responsibility to follow up with my primary care physician.

**SIGNATURE OF PATIENT / EMPLOYEE / LEGAL REPRESENTATIVE:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT** (if applicable) \_\_\_\_\_

**DATE:** \_\_\_\_\_

**Section 4: Vaccination Record**

**FOR ADMINISTRATIVE USE ONLY**

Vaccine	Dose	Route	Date Dose Administered	Lot Number	Expiration Date	Name of Vaccine Administrator RPH./NTERN
<b>MODERNA</b> <input type="checkbox"/> 1st or <input type="checkbox"/> 2nd ..... <b>J &amp; J</b>	0.5 ml	<input type="checkbox"/> IM - L Arm				
<b>Pfizer</b> <input type="checkbox"/> 1st or <input type="checkbox"/> 2nd <input type="checkbox"/> [Booster]	0.3	<input type="checkbox"/> IM - R Arm				

