COVID-19 Vaccine Consent Form
Rx Mart Pharmacy
300 E Sunset Drive, Bellingham, WA 98225
Tel:3609331401 Fax:3603933445

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**	

IS THIS YOUR FIRST ☐ OR SECOND ☐ DOSE OF THE COVID-19 VACCINE? If this is your second dose, what was the date of your first dose? _____

Section 2: Screening Questions

	YES	**NO**
1. Do you have any allergies? Please list:	☐	☐
2. Are you sick today? (For example, cold, fever, or acute illness)	☐	☐
3. Do you have a bleeding disorder or are you on a blood thinner?	☐	☐
4. Are you immunocompromised or are you on a medicine that affects your immune system?	☐	☐
5. Are you pregnant or plan to become pregnant?	☐	☐
6. Are you breastfeeding?	☐	☐
7. Have you received another COVID-19 vaccine?	☐	☐
8. 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**	**Vaccine Manufacturer**	**Lot Number**	**Expiration Date**	**Name of Vaccine Administrator RPH./NTERN**
MODERNA/ J &J	__0.5_ml ☐ 1st __0.5___ml ☐ 2nd	☐ IM - L Arm ☐ IM - R Arm		MODERNA J &J			