COVID-19 Vaccine Consent Form

Patient Information (Vaccine Recipient):

Name (Last)		**Date of Birth**	**Gender**	**Race**	**Age**
Name (First)		**Name** (Middle)	**Mother's Maiden Name**		
Address					
City	**State**	**Zip**	**Phone Number**		

Screening Questions: If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Question	YES	NO	Don't Know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 Vaccine?	☐	☐	☐
• If you have received a dose of COVID-19 Vaccine before: o Vaccine manufacturer (example: Pfizer, Moderna): _____ o Date of first dose: _____ o Date of second dose: _____			
3. Have you ever had an allergic reaction to the following: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• **A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures**	☐	☐	☐
• **Polysorbate**	☐	☐	☐
• **A previous dose of COVID-19 Vaccine**	☐	☐	☐
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	☐
5. **Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication?** This would include food, pet, environmental, or oral medication allergies.	☐	☐	☐
6. Have you received any vaccine in the last 14 days?	☐	☐	☐
7. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?	☐	☐	☐
8. **Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?** *[note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]*	☐	☐	☐
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
10. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
11. Are you pregnant or breastfeeding?	☐	☐	☐

What to Bring to Appointment:

1. **Completed COVID-19 Screening Form**
2. **Prescription Insurance Card and/or Medicare Card (if you do not have prescription insurance there will not be a copay)**

Signature of Person to Receive Vaccine & EUA /VIS and Signature of Parent/Guardian if Patient is < 18 years old:

Signature: _____ **Date: _____**

Parent Name: _____ **Parent Signature: _____**

Please click the link below to access and read the attached information. This is your information to keep.

https://www.fda.gov/media/144414/download

https://www.modernatx.com/covid19vaccine-eua/eua-fact-sheet-recipients.pdf

https://www.janssenlabels.com/emergency-use-authorization/Janssen+COVID-19+Vaccine-Recipient-fact-sheet.pdf

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/pdfs/v-safe-information-sheet-508c.pdf

I believe the benefits outweigh the risks, and I accept full responsibility for any reactions that may result from my receipt of the immunization or the receipt of the immunization by the person named below for whom I am the legal representative. I agree that the immunization record may be shared as stated in the Notice of Privacy Practices, which includes sharing with health care providers and to support the application for payment by Medicare, Medicaid, and other third-party payor. I request the third-party payer to pay any authorized benefits to Spencer's Drugstore on my behalf. The Notice of Deemed Consent for blood borne diseases has been explained to me and I understand it.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any VDH health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.
2. If you should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the tests.

RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read the Notice of Privacy Practices from the Spencer's Drugstore

*****PHARMACY USE ONLY*****

Vaccine	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	□ 1st Dose □ 2nd Dose □ 3rd Dose	□ IM - L Arm □ IM - R Arm		□ Moderna □ Pfizer □ Janssen			

Pharmacist Name who reviewed this form: _____ **Pharmacist Signature**: _____

Questions Adapted from the CDC Prevaccination Checklist for COVID-19 Vaccines