COVID-19 Vaccine Consent Form

Patient Information (Vaccine Recipient):

Name (Last)		(First)	**Date of Birth**	**Gender**
Address				
City	**State**	**Zip**	**Phone Number**	
Primary Care Provider Name:				
Emergency Contact Name:		**Relation:**	**Phone Number:**	

Screening Questions:

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
  ○ Vaccine manufacturer (example: Pfizer, Moderna): _____
  ○ Date of first dose: _____			

3. Have you ever had an allergic reaction to: (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?	☐	☐	☐

Consent (check each box below after reading and signing):

☐ I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet, a copy of which I was provided with this Consent Form. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent Form.

☐ I understand that at this time, the COVID-19 vaccine requires 2 doses given 21-28 days apart depending on the manufacturer. 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 agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur.

☐ I understand that I will be receiving the vaccination at no cost to me.

☐ If insured, **please bring in your prescription and medical insurance cards** for your vaccine appointment. I authorize the pharmacy to bill my insurance on my behalf for the immunization – understanding I will not incur any costs.

If uninsured, you must check the box below to attest that the following information is true and accurate:

☐ I do not have any insurance, including but not limited to, Medicare, Medicaid, or any other private or government-funded benefit plan.

For uninsured patients, please select at least one of the following that you will bring with you to your appointment.

This is needed in order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program.

☐ Social Security Number
☐ State identification number and state of issuance
☐ Driver's license number and state of issuance

Pharmacy Use for Insurance Information

Signature of Person to Receive Vaccine & EUA /VIS (or Signature of Parent/Guardian if Patient is < 18 years old)

Signature: _____ **Date:** _____

*****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	☐ IM - L Arm ☐ IM - R Arm		☐ Moderna ☐ Pfizer			
COVID-19	☐ 1st Dose ☐ 2nd Dose	☐ IM - L Arm ☐ IM - R Arm		☐ Moderna ☐ Pfizer			

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

If **certified vaccinator** is different than the pharmacist who reviewed the form:

Name: _____ **Signature**: _____