COVID-19 Vaccine Consent Form **Booster**

Bob Johnson's Pharmacy

Serving Seattle since 1957

Section 1: Patient Information

NAME (Last)	(First) (Middle Initial)		DATE OF BIRTH	AGE
ADDRESS				GENDER
CITY	STATE	ZIP	PRIMARY PHONE NUMBER	
DATE OF LAST DOSE:	Email		ALTERNATE PHONE NUMBER:	
PRIMARY CARE PHYSICIAN:	PCP Address		PCP Phone Number	
EMERGENCY CONTACT: Name			Relation	Phone Number
ETHNICITY:			RACE:	MOTHER'S MAIDEN NAME
INSURANCE				

Section 2: Screening Questions - *Please answer yes, no, or not applicable*

Have you ever had an allergic reaction to a component of the COVID-19 vaccine including either of the following: • Polyethylene glycol (PEG, found in some medications, such as laxatives and preparations for colonoscopy) • Polysorbate (found in some vaccines, film-coated tablets, and intravenous steroids)?	
Have you ever had an allergic reaction to the COVID19 vaccine?	
Have you ever had an allergic reaction to another vaccine (other than COVID19 vaccine) or an injectable medication?	
Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	
Do you feel sick today?	
Have you tested positive for COVID-19 in the last 14 days?	
Have you been exposed to someone in the past 14 days that was currently positive for COVID-19?	
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	
Do you have a bleeding disorder or are you taking a blood thinner?	
Are you pregnant or breastfeeding?	
Have you had myocarditis or pericarditis after an mRNA COVID-19 vaccine?	

Section 3: Consent

	I have been given a copy or have read, or have had explained to me, the information in the FACT SHEET for the COVID-19 vaccine. I understand this is approved for use in individuals age 12 and above according to the Fact Sheet provided. I have had the chance to ask questions that were answered to my satisfaction. I also have either received, read, or declined to receive Bob Johnson's Pharmacy notice of privacy practices. I also understand I cannot opt out of any reporting that I have received the vaccine.
	I understand the primary series of COVID-19 vaccine requires 2 doses given 3-8 weeks apart for the vaccine. 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. Additional doses may be given according to CDC and Washington State guidelines.
	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 I hereby release Bob Johnson's Pharmacy, their affiliates, employees, directors, and officers from all liability arising from any accident, act of omission or commission, which arises during vaccination.
	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 or pharmacy.
	I authorize the pharmacy to bill for the vaccination on my behalf.
	I attest that the information in this form is accurate to the best of my knowledge

SIGNATURE OF PATIENT / EMPLOYEE / LEGAL REPRESENTATIVE **DATE**

RELATIONSHIP TO PATIENT (if applicable) _____

PFIZER/MODERNA FACT SHEET V. 8/31/22
LEFT OR RIGHT DELTOID

RPH SIGNATURE_____