Stauffer's Drug Store COVID-19 Vaccine Intake Form

All information is protected under HIPAA privacy regulations.

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

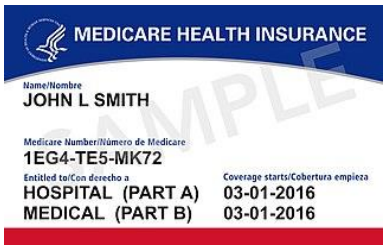
Phone: (_____)_____ Date of Birth: _____

Social Security Number: _____

1. **Are you Medicare Eligible?** ☐ Yes ☐ No

If Yes –> require copy of Medicare card (see sample picture)

Examples: Born 1956 or earlier or younger with disability



2. **Do you have Medicaid, Tricare, or Commercial Insurance?** ☐ Yes ☐ No

If Yes -> require copy of Pharmacy/Prescription insurance card

Note: Pharmacy card should contain an ID#, BIN#, PCN# and Group#

3. **Are you Uninsured?** ☐ Yes ☐ No

If Yes -> please attest that the following information is true to qualify for Federal vaccine coverage:

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

COVID Screening & Consent Form **Stauffer's Drug Store**

Patient Name: **DOB:**	**Preference:** ☐ Left Arm ☐ Right Arm		
Race: ☐ White ☐ Black/African Amer ☐ Asian ☐ Hispanic/Latino ☐ Other			
Receiving: ☐ Moderna 1st Dose ☐ Moderna 2nd Dose ☐ Moderna 3rd Dose ☐ Janssen (J&J) ☐ Pfizer 1st Dose ☐ Pfizer 2nd Dose ☐ Pfizer 3rd Dose	**Yes**	**No**	**Don't Know**
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson)			
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 <u>severe allergic reaction</u> (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 doctor 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?	☐	☐	☐
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 FOR SERVICES: I have been provided with the Vaccine Information Sheet or patient fact sheet corresponding to the vaccine that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to me.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize Stauffer's Drug Store to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid, or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS: I understand that Stauffer's may be required to or may voluntarily disclose my health information to the physician responsible for this protocol, my Primary Care Physician, my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment, or other health care operations.

X _____ _____

Signature of patient to receive vaccine. **Date**