Hina's Pharmacy, Stockdale 661-664-7979

LAST NAME FIRST NAME MIDDLE DOB AGE M F OTHER GENDER

HOME ADDRESS CITY STATE ZIP PHONE # HOME OR CELL

**WHICH ARM DO YOU PREFER FOR VACCINE?** Circle Left or Right Arm

**MOTHER OR GUARDIAN'S FIRST NAME:**_____ **Email Address:** _____

**PLEASE √ ETHNICITY:** Hispanic/Latino/Spanish Origin [ ] YES [ ] NO
**RACE:** [ ] Native American or Alaskan Native [ ] Asian [ ] Black or African American [ ] Pacific Islander or Native Hawaiian
[ ] White [ ] Other

**SCREENING QUESTIONAIRE ON BACK OF PAGE - MANDATORY**

**Mandatory - Last 4 digits of SSN:** _____ **Kaiser ID#** _____

**Medi-Care ID#** _____ **Medi-Cal/Kern Family ID#** _____

**BIN:** _____ **PCN:** _____ **Group:** _____

**ID#:** _____

**By my signature below, I consent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist or technician, where permitted by law or state/federal guidance, employed by Hina's Home Care Pharmacy and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting or arising from my receipt of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination and understand that I am obligated to pay for all products and services received, if applicable. 2) I may be responsible for payment after the state of service if the product or service is billed to my medical benefit. 3) I am of legal age and authorized to execute this consent form. 4) I will immediately alert the pharmacist of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine. 5) I have been counseled about potential side effects after vaccination, when they may occur, and when and where is should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects. 6) I should remain in the area for 15 minutes after the vaccination for observation. 7) I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization ("EUA") provided for the vaccine(s) to be administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). 8) This vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting by my pharmacy or its business associate to an immunization registry, which may share my immunization data with others, and to my primary care physician, the authorizing physician, or the local Department of Health, if applicable, and I authorize these disclosures.**

_____ _____
**Signature of Patient or Caregiver of the Patient** **Date**

**For Pharmacy Use Only**

1ST 2ND BOOSTER PEDIATRIC (0.2ML) PFIZER LOT #_____ 1ST 2ND 3RD BOOSTER PFIZER (0.3ML) LOT# _____

1ST 2ND 3RD BOOSTER MODERNA LOT# _____ (DOSE 0.25ML OR 0.5ML) 1ST BOOSTER JANSSEN (0.5ML) LOT# _____

**Initials of RPH/Administrator:** _____

**Attach Sticker Here**

**RPh: Signature indicates (1) VIS/EUA Provided and (2) Counseling Offered (Please Circle) Accepted or Declined**

# Prevaccination Checklist for COVID-19 Vaccines

## For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. 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.

Name

Age

| | 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) ☐ Another Product | | | |
| • Did you bring your vaccination record card or other documentation? *(yes/no)* | | | |
| 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 caused hives, swelling, or respiratory distress, including wheezing.)* | | | |
| • A component of a COVID-19 vaccine, including either of the following: | | | |
| o Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures | ☐ | ☐ | ☐ |
| o Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids | ☐ | ☐ | |
| • 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 caused hives, swelling, or respiratory distress, including wheezing.)* | ☐ | | |

5. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (i.e., HIV infection, cancer)
- ☐ Take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of herparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers

Form reviewed by

Date



Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists