

Hina's Pharmacy, Stockdale 661-664-7979

LAST NAME	FIRST NAME	MIDDLE	DOB	AGE	GENDER		
					M	F	OTHER

HOME ADDRESS	CITY	STATE	ZIP	PHONE # HOME OR CELL
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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 QUESTIONNAIRE 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 I 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 Pfizer Pediatric (0.2ml) Lot# _____

[Attach Sticker Here]

1st 2nd Booster 4th Pfizer (0.3ml) Lot# _____

Moderna Bivalent Booster (0.5ml) Lot# _____

Pfizer Bivalent Booster (0.3ml) Lot# _____

Initials of RPh/ Administrator: _____

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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever received a dose of COVID-19 vaccine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • If yes, which vaccine product did you receive? | | | |
| <input type="checkbox"/> Pfizer | | | |
| <input type="checkbox"/> Moderna | | | |
| <input type="checkbox"/> Janssen
(Johnson & Johnson) | | | |
| <input type="checkbox"/> Another Product | | | |
| • Did you bring your vaccination record card or other documentation? (yes/no) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had an allergic reaction to: | | | |
| <i>(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.)</i> | | | |
| • A component of a COVID-19 vaccine, including either of the following: | | | |
| <input type="checkbox"/> Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • A previous dose of COVID-19 vaccine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>(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.)</i> | | | |
| 5. Check all that apply to you: | | | |
| <input type="checkbox"/> Am a female between ages 18 and 49 years old | | | |
| <input type="checkbox"/> Am a male between ages 12 and 29 years old | | | |
| <input type="checkbox"/> Have a history of myocarditis or pericarditis | | | |
| <input type="checkbox"/> Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies | | | |
| <input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum | | | |
| <input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection | | | |
| <input type="checkbox"/> Have a weakened immune system (i.e., HIV infection, cancer) | | | |
| <input type="checkbox"/> Take immunosuppressive drugs or therapies | | | |
| <input type="checkbox"/> Have a bleeding disorder | | | |
| <input type="checkbox"/> Take a blood thinner | | | |
| <input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT) | | | |
| <input type="checkbox"/> Am currently pregnant or breastfeeding | | | |
| <input type="checkbox"/> Have received dermal fillers | | | |

Form reviewed by _____

Date _____