Hina's Pharmacy, Stockdale 661-664-7979, White Lane 661-282-8805

LAST NAME	FIRST NAME	MIDDLE	DOB	AGE	M F OTHER GENDER

HOME ADDRESS	CITY	STATE	ZIP	PHONE # HOME OR CELL

PLEASE √ ETHNICITY: [ ] Hispanic [ ] Not Hispanic
RACE: [ ] Native American or Alaskan Native [ ] Asian [ ] Black or African American [ ] Pacific Islander or Native Hawaiian [ ] White [ ] Other

WHICH ARM DO YOU PREFER FOR VACCINE? Circle Left or Right
WHAT DOSE ARE YOU GETTING? Circle 1st or 2nd If 2nd, Which Product did you get?Pfizer Moderna 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

Vaccine Name	Lot#	Exp. Date	Manufacturer	Dose (ml)	Dose #	Route	Site (Circle)

Attach Sticker Here

Signature of RPh: ____________________________

Initials of 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:

Patient Name

Age

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.

	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 ☐ Another product			
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 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?			

Form reviewed by ______________________ **Date** ____________

01/05/2021

Adapted with appreciation from the Immunization Action

PATIENT SIGNATURE ____________________