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COVID-19 IMMUNIZATION CONSENT FORM

Name: ______________________________ Date of Birth: _______________ Sex: ☐ M ☐ F

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American ☐ White ☐ Other Race ☐ Refuse to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refuse to Answer

Address: ____________________________ City/State: ______________ Zip Code: _________

Phone: __________________ Primary Care Physician: __________________

Please answer the following for the person receiving the vaccine today:	**Circle One:**	
1. In the past 2-14 days have you experienced fever or chills, cough, shortness of breath, fatigue, muscle/body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, o1r diarrhea?	YES	NO
2. In the past 2-14 days, are you aware of being exposed to someone who tested positive for COVID-19?	YES	NO
3. Have you received any other vaccinations in the last 14 days?	YES	NO
4. Have you previously tested positive for COVID-19? If so, when? __________________	YES	NO
5. Have you had immune globulin or a blood transfusion in the past 90 days (3 months)?	YES	NO
6. Have you already had the first dose of a COVID-19 vaccine? If so, when and which manufacturer? __________________	YES	NO
7. Have you ever had a severe reaction to any vaccine / medication that required medical care? If so, please describe reaction: __________________	YES	NO
8. Are you pregnant or planning pregnancy in the next 3 months?	YES	NO
9. Are you currently breastfeeding?	YES	NO
10. Are you immunocompromised or receiving immunosuppressant therapy?	YES	NO
11. Are you a healthcare worker or an employee at a healthcare facility?	YES	NO

12. List any diseases you have been diagnosed with:

____

13. List all prescriptions and/or over the counter medications you take routinely:

____

14. List any drug allergies and reactions:

____

I have read, or have had explained to me, information about the disease and the vaccine(s) listed. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) cited and ask that the vaccine(s) be given to me or the person named above (for whom I am authorized to make this request). I understand that it is recommended that I stay on location for a minimum of 15 minutes following the injection. I understand that a vaccine information statement (VIS), or equivalent, was given and all of my questions have been answered to my satisfaction.

HIPAA Release: HIPAA requires that we give you this "Notice of Privacy Practices" (NOPP) and make a good faith effort to obtain your written acknowledgement that you were given this notice. Upon giving you this notice, you will be asked to sign this document acknowledging that you received this notice. We appreciate your cooperation in reviewing this notice and in giving us your written acknowledgement.

Signature: ______________________________ **Today's Date:** ______________

FOR PHARMACY USE ONLY:

Vaccine	Mfr.	Lot #	Exp.	Site	Date Given	Administrator
COVID-19						

Pharmacy Prescription Label:

Special notations or circumstances below:

TO THE OFFICE OF ____

Recently our mutual patient received an immunization at **Lynn's Pharmacy Hewitt**. We are sending this communication in order for you to complete your health records. If you have any additional questions or would you like to inquire about the immunizations we currently provide, please feel free to contact us.

Pharmacist Administering Vaccine(s):

Printed Name: _________________________________

Signature: _____________________________________

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