COVID-19 VACCINE SCREENING AND CONSENT FORM

Quik-Stop Pharmacy

3506 E. Lincoln Hwy, Thorndale, PA 19372

Phone: (**610**) **384-6100**

Name:

First:	Last Name	Middle Initial	DOB: / /
Address	City	State	Zip
Phone: Mobile		Home:	

Sex:	**Race**	**Ethnicity**
☐ Male ☐ Female	☐American Indian or Alaskan Native ☐Native Hawaiian or other ☐ Other Asian ☐Unknown ☐ Asian ☐ Pacific Islander ☐ Other Nonwhite ☐ Black or African American ☐White ☐Other Pacific Islander	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Moderna	☐First Dose	☐Second Dose	☐Third Dose
Pfizer	☐First Dose	☐Second Dose	☐Third Dose
Janssen	☐		

SCREENING QUESTIONS

Please check YES or NO for each question

	Yes	No
1. Are you sick today?		
2. Do you have a long-term health problem with heart disease, kidney disease, metabolic disorder (e.g., diabetes), anemia or other blood disorders?		
3. Do you have long term health problem with lung disease or asthma? Do you smoke?		
4. Do you have allergies or reactions to any medications, foods (i.e., eggs), latex or any vaccine component (e.g., neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast, or yeast, **polythethylene glycol [PEG], polysorbate?**		
5. Have you ever had a serious reaction after receiving a vaccination		
6. Do you have a neurological disorder such as seizures or other disorders that affected the brain or have had a disorder that resulted from a vaccine (e.g., Guillain-Barre Syndrome)?		
7. Are you immunocompromised or on a medication (e.g., prednisone) that affects your immune system?		
8. For women: are you pregnant or could you become pregnant in the next three months?		
9. For women: are you currently breastfeeding?		
10. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
Section 2: COVID-19 SCREENING QUESTIONS *Please check YES or NO for each question*		
11. Have you tested positive for and/or been diagnosed with COVID-19 infection within the last 10 days?		
12. Have you had any COVID-19 Antibody therapy within the last 90 days (e.g., Regeneron, Bamlanivimab, COVID Convalescent Plasma, etc.?)		
13. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive:		
14. Did you bring your Immunization Record Card with you?		

☐	I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to Quik-Stop Pharmacy, or its associates to administer the COVID-19 vaccine.
☐	I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
☐	I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
☐	I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital
☐	On behalf of myself, my heirs, and personal representatives, I hereby release and hold harmless Quik-Stop Pharmacy and their staffs, agents, contractors, and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.
☐	I acknowledge that: (a) I understand the purposes/benefits of Pennsylvania immunization registry and (b) Quik-Stop Pharmacy will include my personal immunization information in PA SIIS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
☐	I further authorize Quik-Stop Pharmacy to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to Quik-Stop Pharmacy with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if Quik-Stop Pharmacy invoices me after the time of service, upon receipt of such invoice.
☐	I acknowledge receipt of the Notice of Privacy Rights.

Signature of Patient or Authorized Representative: _____

Date of Signature: \ \

Print Name of Representative and Relationship to Person Receiving Vaccine:

For Vaccinator Only:							
Vaccine Name	Lot	Expiration Date	Dosage	Site	Date of EUA Fact Sheet	Initials	Date
		/ /		RD LD	/ /		/ /
		/ /		RD LD	/ /		/ /
		/ /		RD LD	/ /		/ /
		/ /		RD LD	/ /		/ /

Vaccinator Print Name	Signature	Date
		/ /