COVID-19 VACCINE SCREENING AND CONSENT FORM \ Quik-Stop Pharmacy

Pasiis	☐
HRSA	☐

Name *(please print)*:	DOB:

SCREENING QUESTIONS *Please check YES or NO for each question*			
1	Are you feeling sick today?	☐ Yes	☐ No
2	In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	☐ Yes	☐ No
3	Have you been treated with antibody therapy for COVID-19 or been diagnosed with MIS-A or MIS-C in the past 90 days (3 months)? If yes, when did you receive the last dose? Date:	☐ Yes	☐ No
4	Do you carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, foods, vaccines or latex?	☐ Yes	☐ No
5	Are you pregnant or lactating, or considering becoming pregnant?	☐ Yes	☐ No
6	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	☐ Yes	☐ No
7	Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?	☐ Yes	☐ No
8	Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive:	☐ Yes	☐ No
9	Did you have any allergy symptoms after a COVID-19 vaccine?	☐ Yes	☐ No

☐	I certify that I am: (a) the patient or the legal guardian of the patient and confirm that the patient is at least 18 years of age; or 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 may not have 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 if Applicable:

Vaccinator Only:

Vaccine Site	
LD ☐	RD ☐

PLACE VACCINE STICKER HERE

Vaccine Name	Lot	Expiration Date	Dosage (ml)	Date of EUA Fact Sheet

Vaccinator Print Name	Signature	Date