JONES DRUG STORE COVID-19 VACCINE SCREENING & CONSENT FORM

Last Name: _____ First Name: _____ MI: _____ DATE: _____

DOB: _____ AGE: _____

Race/Ethnicity: (circle one) American Indian/Alaska Native Black/African American Asian

Hispanic/Latino White Pacific Islander Other

Street Address: _____ City: _____ State: _____

Zip Code: _____ County: _____ Phone Number: _____

Primary Care Physician: _____ SS #: _____

Which COVID-19 vaccine and dose are you receiving today? (circle one and check box)

Pfizer Moderna Janssen (J&J) ☐ 1st dose ☐ 2nd dose ☐ 3rd dose ☐ 4th dose

(1ST BOOSTER) (2ND BOOSTER)

*****_Pharmacist: check vaccination card for 1st dose manufacturer, if applicable_

SCREENING QUESTIONAIRE

The following questions will help us determine your eligibility to be vaccinated today, if under 18 years old, parent or legal guardian must fill out and sign.

COVID-19 VACCINE SCREENING QUESTIONS	YES	NO	DON'T KNOW
Are you (or your child, if filling out for him/her) feeling sick today?			
Have you (or your child) ever received a dose of COVID-19 Vaccine? **If yes, which vaccine product did you receive? (circle)** **Pfizer Moderna Other**			

(OVER)

COVID-19 VACCINE SCREENING QUESTIONS (CONTINUED)	YES	NO	DON'T KNOW
Have you (or your child) ever had an allergic reaction to: **this would include a severe allergic reaction (e.g. anaphylaxis) that required treatment with epinephrine 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, respiratory distress, including wheezing or trouble breathing*			
A component of the COVID-19 vaccine, including polyethylene glycol, which is found in some medications, such as laxatives			
Polysorbate			
A previous dose of the COVID-19 vaccine			
Have you (or your child) ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?			
Have you (or your child) received any vaccine in the last 14 days?			
Have you (or your child) ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
Have you (or your child) received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19?			
Do you (or your child) have a bleeding disorder or are you taking a blood thinner?			
Are you pregnant or breast feeding?			
Which arm would you like your vaccine given in today? (please circle one)	**LEFT**	**RIGHT**	

(NEXT PAGE)

I certify that I am: (a) the patient and at least 18 years of age or (b) the parent or legal guardian of the patient. Furthermore, I hereby give my consent to **JONES DRUG STORE** to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the above vaccine(s) and have received, read, and/or had explained to me the Vaccine Information Statements/Vaccine Fact Sheet(s) on the vaccine(s) 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. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, 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(s) listed above. I acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. I acknowledge that, depending upon my state's law, I may prevent the disclosure of my immunization information by the Provider to the State Registry by using the opt-out form. The Provider will, if my state permits, provide me with an Opt-Out form. I understand that, depending on my state's laws, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the Provider reporting my immunization information to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my information as required or permitted by law. I voluntarily authorize and direct my healthcare provider, **JONES DRUG STORE**, to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at **JONES DRUG STORE**, my primary care physician, my insurance and/or state or federal registries, where required, for the purpose of treatment, payment or other healthcare operations. I further agree to be fully financially responsible for any cost sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service.

Patient/Guardian Signature: _____ Date: _____

Print Name: _____

BELOW TO BE FILLED OUT BY THE PHARMACY

☐ **PFIZER 0.3ML** ☐ **MODERNA 0.5ML** ☐ **MODERNA 0.25ML** ☐ **JANSSEN 0.5ML (J&J)** ☐ **PFIZER PED 0.2ML**

Administration Date: _____ Lot #: _____ Exp Date: _____

Administration Site: (circle one) Left arm Right arm Left Thigh Right Thigh

Administration Route: IM

Patient temperature obtained by pharmacist: _____ Date: _____

Date Fact sheet was given to patient: YES NO

Administering Pharmacist Signature: _____ Date: _____

Patient's Insurance (circle one)

MEDICARE MEDICAID

COMMERCIAL UNINSURED