COVID-19 Screening and Consent/Declination (Please complete the following):

Print Name:_____ Date of Birth____/____/____

Street Address:_____ Phone#_____
Physical address City Zip code

Gender: M_____ F_____ E-Mail address:_____

Are you a new patient at Drug Mart? If yes, we will need a copy of your insurance card. Uninsured? We will need the following information:
SS#_____ If no SS#, need DL# or State ID#:_____ State of Residence_____

Vaccine: _____ MODERNA _____ JANSSEN Accept Immun:_____ Decline Immun:_____

	YES	NO
Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine: ____ Moderna ____ Janssen		
Have you tested positive for COVID-19 in the last 90 days?		
Do you have any COVID-19 related symptoms (fever, cough, shortness of breath, loss of taste and/or smell, headache, congestion, sore throat, nausea, vomiting, diarrhea)?		
Have you been in close contact of a confirmed COVID-19 case in the last 14 days?		
Have you received passive antibody therapy as treatment for COVID-19 in the last 90 days?		
Have you had a vaccine in the past 2 weeks?		
Are you sick today (aside from COVID-19 symptoms)?		
After review of the FDA Fact Sheet, to your knowledge, do you have an allergy to a component of the vaccine?		
Have you ever had a serious reaction to a vaccine in the past (hives, itching, difficulty breathing)?		
Have you **EVER** had anaphylaxis (severe, potentially life-threatening allergic reaction) **NOT** related to an injection?		
Do you have a bleeding disorder or are you taking a blood thinner?		
Do you have a history of Guillain-Barre syndrome?		
FEMALES ONLY: Could you be pregnant, planning on becoming pregnant in the next two months or are you breastfeeding?		

****If yes to any question, our pharmacists will consult with you.**

I acknowledge that I am aware of the following:

1. I know the Food and Drug Administration (FDA) has authorized the emergency use of this vaccine. I know it is not a fully licensed FDA vaccine.
2. I know I should report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967 or https://vaers.hhs.gov/reportevent.html.
3. I know I must get 2 doses of the Moderna COVID-19 vaccine and receive the same vaccine each time **OR** 1 dose of the Janssen COVID-19 vaccine.
4. I have been given a copy and I have read the information in the Fact Sheet for the COVID-19 vaccine I am receiving.
5. I have had the chance to ask questions prior to receiving the vaccine and received appropriate feedback.
6. I understand the benefits and risks of the vaccine.

Signature: _____ **Date**: _____/_____/_____

----------FOR PHARMACY STAFF ONLY----------

_____1st Dose _____2nd Dose – Date of 1st Dose _____

DATE ADMINISTERED	MODERNA Dose: **0.5 ML** Site: **Deltoid** ___Left ___Right	JANSSEN Dose: **0.5 ML** Site: **Deltoid** ___Left ___Right	LOT # and EXP.	ADMINISTERED BY:	ENTERED INTO ALERTIIS: (initials)