Peopless Pharmacy LLC

COVID-19 Vaccination Consent Form

Last Name *(Please print)*	First Name	MI	Date of Birth	☐ Male ☐ Female ☐ Other
Address		City	State	Zip
Phone Number	Email			

CIRCLE PREFERENCE: MODERNA | P F I Z E R | JANSSEN | Boost: (Y) or (N)

The vaccine that will be administered may not be your preferred vaccine. This depends on the availability at our pharmacy!

Do you have insurance? ☐ No ☐Yes

For uninsured patients, please select at least one of the following to bring with you to your appointment

☐ Social Security ☐State identification number and state of issuance ☐ Driver's license number and state of issuance

SCREENING FOR VACCINATION ELIGIBILITY

1. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any vaccine or injectable therapy, or a history of anaphylaxis due to any cause?	Yes	No
2. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of a COVID-19 vaccine, including lipid nanoparticles or polyethylene glycol (PEG)?	Yes	No
3. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?	Yes	No
4. Are you under age 5?	Yes	No
5. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?	Yes	No
6. Do you have a bleeding disorder or are you taking a blood thinner?	Yes	No
7. Have you tested positive for COVID-19 in the last 10 days?	Yes	No
8. Are you currently in quarantine for COVID-19 exposure?	Yes	No
9. Have you been diagnosed with Multisystem Inflammatory Syndrome in adults or children in the last 90 days? (If you answer yes to this question, it is recommended you consult with your physician prior to receiving the COVID-19 vaccine)	Yes	No
10. Have you ever been diagnosed with myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the outer lining of the heart)?	Yes	No
11. If this is your second dose, when was the date of your first dose?	/	/
12. If this is your second dose, which vaccine did you receive (Pfizer or Moderna)?		
13. Are you moderately to severely immunocompromised?	Yes	No
14. If this is your third dose, when was the date of your second dose?	/	/
15. If this is your third dose, which COVID-19 vaccine did you receive previously (Pfizer or Moderna only)?		
16. If this is a booster dose, when was the date of your second dose of the Moderna or Pfizer-BioNTech COVID-19 vaccines or the date of your first dose of the Janssen (J/J) vaccine?	/	/

CONSENT FOR VACCINATION

I will/have reviewed my answers to the questions above with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization (EUA) Fact Sheet or Vaccine Information Statement (VIS) provided to me today. I understand the benefits and risks of the vaccine. I understand that I can review a Notice of Privacy Practice at the time of vaccination.

By signing this form, I give permission for a vaccine to be administered to the person above and a record of the vaccination to be entered into the **Virginia Immunization Information System** (VIIS) for care coordination and to monitor statewide vaccination coverage. For more information about VIIS, please go to https://www.vdh.virginia.gov/immunization/viis/. Further, I agree that the information above is correct.

Signature of Parent/Guardian/Patient _____ _____**Date**

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FOR ADMINISTRATIVEUSE ONLY	**EUA or VIS Date:**

Vaccine	**Date Vaccination and EUA/VIS Given:**	**Route** **IM** *R L*	**Manufacturer**	**Lot No.**	**Printed Name and Signature of Vaccine Administrator**