Peoples Pharmacy LLC

COVID-19 VACCINE

General Information about person to receive vaccine | PLEASE FILL EVERYTHING

Name:_____**Birth date**:___/___/_____ **Age**: _____ **Sex**: ☐ Male ☐ Female

Race: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other **Ethnicity**: ☐Hispanic ☐Non-Hispanic

Address:_____**City**:_____**State**:_____**Zip**: _____

Phone:_____**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

CIRCLE PREFERENCE: MODERNA(2doses) | P F I Z E R (2doses) | JANSSEN(1dose)

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

The following questions will help determine if there are any reason you should not receive a COVID-19 immunization injection or any precaution our pharmacy need to take.

Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.

Do you have any chronic conditions? (Diabetes, high blood pressure, kidney disease, COPD, etc.)? ☐ No ☐Yes

If yes, list all:_____

Are you or the person to be vaccinated a health care worker? Or can be considered as essential worker? ☐ No ☐Yes

Are you or the person to be vaccinated sick in the past 14-30 days or today? ☐ No ☐Yes

Have you or the person to be vaccinated ever received a COVID-19 vaccine? ☐ No ☐Yes

If yes, date:_____Type/Brand of COVID vaccine:_____

Do you or the person to be vaccinated have an allergy to any medications, food, vaccine, or latex? ☐ No ☐Yes

List all allergies: _____

Have you or the person vaccinated ever had an allergic reaction to: A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures ☐ No ☐Yes

Have you or person to be vaccinated ever had an allergic reaction to: Polysorbate or a previous COVID-19 Vaccine? ☐ No ☐Yes

Have you or the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy? ☐ No ☐Yes

Are you or the person to be vaccinated pregnant or breastfeeding? ☐ No ☐ Yes

Do you or the person to be vaccinated have a weakened immune system caused by something such as HIV infection or cancer? ☐ No ☐Yes

Do you or the person to be vaccinated have a bleeding disorder or are they taking a blood thinner? ☐ No ☐Yes

Have you or the person to be vaccinated received any other vaccines in the past 14 days? ☐ No ☐Yes

Have you or the person to be vaccinated ever tested positive for the COVID-19? ☐ No ☐ Yes

Have you or person to be vaccinated received passive antibody therapy as treatment for COVID-19? ☐ No ☐ Yes

If you have any questions at all, the pharmacist is available to you before you get your vaccine.

Our pharmacy abides by HIPAA rules & regulations.

Use your smartphone to tell CDC about any side effects after getting the COVID-19 vaccine. You'll also get reminders if you need a second vaccine dose.

Sign up with your smartphone's browser at
vsafe.cdc.gov

OR

Aim your smartphone's camera at this code

HOW CAN I LEARN MORE?

- Ask the vaccination provider.
- Visit CDC at https://www.cdc.gov/coronavirus/2019-ncov/index.html.
- Visit FDA at https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization.
- Contact your local or state public health department.

Learn more about ***v-safe*** www.cdc.gov/vsafe

ADDITIONAL INFORMATION

If you have questions, visit the website or call the telephone number provided below.

To access the most recent Fact Sheets, please scan the QR code provided below.

Moderna COVID-19 Vaccine website	Telephone number
www.modernatx.com/covid19vaccine-eua	1-866-MODERNA (1-866-663-3762) Moderna COVID-19 EUA FACT SHEET

QR Code	Fact Sheets Website	Telephone numbers
	www.janssencovid19vaccine.com. Janssen COVID-19 EUA FACT SHEET	US Toll Free: 1-800-565-4008 US Toll: (908) 455-9922

Global website	Telephone number
www.cvdvaccine.com	PFIZER EUA FACT SHEET 1-877-829-2619

I have read, or have had explained to me, the Emergency Use Authorization (EUA) for COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent or guardian).

I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.

Print Parent/Guardian name, if different from client: _____

Client/Parent/Guardian Signature:_____Date: _____

Emergency Contact Name:_____**Relationship to Emergency Contact**: _____

Emegency Contact Phone Number:_____**Work Phone**: _____

INSURANCE INFORMATION

(Please bring your insurance card to the receptionist at your appointment)

*NOTE: if you have **MEDICARE- RED &BLUE CARD** please put it in primary insurance/ If not applicable: put N/A*

Primary Insurance: _____

Subscriber's Name:_____Date of birth: _____

Group No:_____RX PCN: _____

Member ID#:_____RX BIN: _____

Client's relationship to subscriber: _____

The above information is true to the best of my knowledge. If qualified, I authorize billing to my insurance company and release of information required to process my claims. I understand that I will be receiving the vaccination at *no cost to me*. If insured, I authorize the pharmacy to bill my insurance on my behalf for the immunization –understanding that *I will not incur any costs*. If uninsured, I attest that I do not have any insurance, including, but not limited to Medicare, Medicaid, or any other private or government-funded benefit plan. I authorize my insurance benefits be paid directly to Peoples Pharmacy LLC. If uninsured, I authorize the pharmacy to use my social security number, state identification number, or driver's license number to bill the United States Health Resources & Services Administration's COVID-19 Program on my behalf for the immunization - understanding that *I will not incur any costs*. I understand that at this time, COVID-19 vaccines require 2 doses given 21-28 days apart dependent on the manufacturer. If this is my first dose of the COVID-19 vaccine and a second dose is required (Pfizer and Moderna only), I intend to receive a second dose of the same vaccine in accordance with the timeframe specified: Moderna 28-42 days | Pfizer 21-42 days. There is currently limited information on the effectiveness of receiving your second shot earlier than recommended or later than 6 weeks after the first shot.

Client Signature_____**Date**_____

*FOR OFFICE USE ONLY: RECEIVED:*_____

Our pharmacy abides by HIPAA rules & regulations.