Township Pharmacy COVID-19 Vaccine Consent Form

First Name:_____ Last Name:_____MI:_____ Gender: M F

DOB: _____Age:_____

Phone:_____Email:_____

Home Address:_____City:_____State:_____Zip:_____

Hispanic/Latino? Yes No Race: White Asian Black Pacific Islander Native American Other

1.Are you feeling sick today? Y N

2.Which Vaccine would you like to receive today? (please circle one)

Pfizer 1st 2nd Moderna 1st 2nd Janssen Other _____

3.Have you ever had an allergic reaction to: Y N

*a component of the COVID-19 vaccine, including polyethylene glycol, which is found in other medications such as laxatives and colonoscopy preparations?

*Polysorbate Y N

*A previous dose of COVID-19 vaccine Y N

4.Have you ever had an allergic reaction to another vaccine (other than the COVID-19 vaccine) or an injectable medication? Y N

5.Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine? Y N

6.Have you received any other vaccine in the last 14 days? Y N

7.Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? Y N

8.Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? Y N

9.Do you have a weakened immune system caused by something such as HIV infection or cancer of do you take immunosuppressive drugs or therapies? Y N

10. Do you have a bleeding disorder or are you taking a blood thinner? Y N

11.Are you pregnant or breastfeeding? Y N

Do you have health insurance? Y N Insurance Co Name:_____RX BIN #_____RX PCN#_____

ID number:_____RX Group #:_____

Consent for Treatment and Privacy Notice

I certify that the information I have provided us true and accurate. I have had a chance to review the Covid-19 vaccine information (EUA Fact Sheet) and consent to receive the vaccine. I have had a chance to ask questions, which, were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine. I understand and agree that information related to my vaccine administration may be recorded in the Utah Statewide Immunization information System (USIIS). I hereby release Township Professional Pharmacy, and its employees, from all claims arising from such immunizations. We are required to inform you of our privacy practices for the information we collect and keep about you. I have been given a copy of Township Pharmacy's Notice of Privacy Practices and have had an opportunity to ask questions about how my information may be used.

Signature: _____Date:_____

Relationship to Client: (circle one) Self Parent Legal guardian Other_____

For Pharmacy Use

Date	Manufacturer	Lot#	Expiration	Dose	Route	Deltoid	Vaccinator
					IM	R L	