SUNRISE PHARMACY - COVID-19 CONSENT FORM AND SCREENING QUESTIONNAIRE

Name_____ Date of Birth_____Gender____

Address_____CITY_____STATE_____ZIP_____

Race/Ethnicity_____ SSN#_____Phone_____

Medicare ID_____ Profession/Employer_____ BADGE #_____

Do you have Insurance? YES NO

Plan Name Plan group ID # Plan Individual ID #

BIN # PCN # Plan Responsible Person Name

I have received a copy of Emergency Use Authorization for the COVID-19 vaccine. I have read it and I understand the information. I have had a chance to ask questions and I believe I understand the benefits and risks of the COVID-19 vaccine request. I ask that the vaccine be administered to me or the person named above whom I am authorized to make this request for. I agree to allow Sunrise Pharmacy to release information to the Arizona State Immunization Information System (ASIIS) to record that I (or for the person whom I am authorized to consent) have received this COVID-19 vaccine requested.

_____ _____ _____

Name of Patient or Parent/Guardian Signature of Patient or Parent/Guardian DATE

COVID-19 Screening Questions

	YES	NO
1. Are you feeling sick today?		
2. Have you had a positive COVID-19 test in the past 3 months/ 90 days?		
3. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?		
4. Are you allergic to any medication, food, vaccine component, or latex?		
5. Do you have bleeding disorder or are you currently taking a blood thinner?		
6. Have you had seizures, brain or other nervous system problems?		
7. For WOMEN – are you pregnant or currently breast-feeding or is there a chance you could become pregnant during the next month? If YES - DON'T VACCINATE		
8. Have you received any vaccination in the past two weeks/14 days?		
9. Have you received passive antibody therapy as treatment for COVID-19		
10. Have you ever received a dose of COVID-19 vaccine? If yes, which Vaccine Pfizer_____ Moderna_____ Date Received_____		

OFFICE USE ONLY

VACCINE	LOT #	EXP. Date	Route - Site	DATE	Administrator Name , Title
			__IM LEFT __IM RIGHT		