COVID-19 Vaccine Registration Form — Medical Arts Pharmacy

Name (Last)	(First)		**Date of Birth**	**Gender**
Address			**Race/Ethnicity**	**Weight**
City	**State**	**Zip**	**Phone Number**	

Emergency Contact Name: **Relationship:** **Phone Number:**

Primary Care Physician Name: **Primary Physician Address:**

PATIENT QUESTIONS – ANSWER THE DAY OF VACCINATION

1.	**Are you feeling sick today?**	☐ No	☐ Yes
2.	**Have you ever received a dose of COVID-19 Vaccine?**	☐ No	☐ Yes
	• **If you have received a dose of COVID-19 Vaccine before:** o Vaccine manufacturer (example: Pfizer, Moderna, Janssen):_____ o Date of First Dose:_____		
3.	**Have you ever had an allergic reaction to:** (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)		
	• **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
	• **Polysorbate**	☐ No	☐ Yes
	• **A previous dose of COVID-19 Vaccine?**	☐ No	☐ Yes
	• **Any other vaccine or injectable medication?**	☐ No	☐ Yes
	• **Something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication?** (This would include food, pet, environment, or oral medication allergies)	☐ No	☐ Yes
4.	**Have you received any vaccine in the last 14 days?**	☐ No	☐ Yes
5.	**Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?**	☐ No	☐ Yes
6.	**Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?** [Note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy.]	☐ No	☐ Yes
7.	**Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressant drugs or therapies?**	☐ No	☐ Yes
8.	**Do you have a bleeding disorder or are you taking blood thinner?**	☐ No	☐ Yes
9.	**Are you pregnant or breastfeeding?**	☐ No	☐ Yes

I request the vaccine to be given to me or to the person named above, a minor for whom I represent and I am authorized to sign this consent form. I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet (https://www.fda.gov/media/146305/download), a copy of which I was provided with this consent form (online or in print). I have had a chance to ask questions that were answered to my satisfaction. I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur. 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. 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, some 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 in the Fact Sheet to complete the series. I acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and that the pharmacy may disclose my information to the State Registry.

Patient Consent/Signature (or parent/guardian if patient is age 18 or under) **Date of Consent**

Insurance Type:
☐ Medicare
☐ Medicaid/Commercial
☐ Uninsured

If Uninsured: MUST OBTAIN one of the following:
☐ Social Security Number _____
☐ State ID Number _____ State of Issuance _____
☐ Driver's License Number _____ State of Issuance _____

If Insured: Obtain insurance card
Cardholder Name:
Relationship: ___ Self ___ Spouse ___ Dependent
BIN: PCN:
ID: RxGrp:

PHARMACY USE ONLY

Vaccine	Dose in Series	Route	Date	Manufacturer	Lot Number	Expiration	Name/Signature of Certified Vaccine Administrator
COVID-19	☐ First/J&J ☐ Second	☐ IM – L Arm ☐ IM – R Arm					

Billing Submitted: ☐ Notes:

☐ **CPESN Reporting**

☐ **Reported** to State Immunization Information System (ISS)
☐ **Reported** to Physician on Protocol
☐ **Reported** to Patient's Primary Physician

Pharmacist Name who reviewed this form: _____ **Signature:** _____