OAKSIDE CARE PHARMACY
"Where your health and care is our priority"

440 Lehigh Street, Reading, PA 19601
Phone 484-663-5760

COVID-19 VACCINE SCREENING AND CONSENT FORM

SECTION 1: INFORMATION ABOUT YOU (PLEASE PRINT)

Name: Last:	First:		Middle Initial:
Date of Birth: Month Day Year	**Mobile Phone Number (Patient or Guardian):** ( )		
Address:		**Apt/Room #:**	
City:	**State:**	**Zip:**	
Sex (Gender assigned at birth) ☐ Female ☐ Male	**Race** ☐ American Indian or Alaska Native ☐ Native Hawaiian or other ☐ Other Asian ☐ Unknown ☐ Asian ☐ Pacific Islander ☐ Other Nonwhite ☐ Black or African American ☐ White ☐ Other Pacific Islander		**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Rx Primary Insurance ID #: ______________________ Rx Grp #: ____________________ Rx BIN#:____________________

Rx PCN#:___________________________

Medicare ID#:_____________________

SECTION 2: COVID-19 SCREENING QUESTIONS

Please check YES or No for each question.	**Yes**	**No**
1. Do you have today or have you had at any time in the last 10 days a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?		
2. Have you tested positive for and/or been diagnosed with COVID-19 infection within the last 10 days?		
3. Have you had a severe allergic reaction (e.g. needed epinephrine or hospital care) to a previous dose of this vaccine or to any of the ingredients of this vaccine (Polyethylene Glycol [PEG] or Polysorbate)?		
4. Have you had any other vaccinations in the last 14 days (e.g. influenza vaccine, etc.)?		
5. Have you had any COVID-19 Antibody therapy within the last 90 days (e.g. Regeneron, Bamlanivimab, COVID Convalescent Plasma, etc.)		
6. Do you carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, foods, vaccines or latex?		
7. For women, are you pregnant or is there a chance you could become pregnant?		
8. For women, are you currently breastfeeding?		
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?		
10. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
11. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive: If yes, which vaccine product did you receive? Pfizer Moderna Another Product ______________________		

I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet, a copy of which I was provided in with this Consent Form. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or the person named above, a minor for whom I represent that I am authorized to sign this Consent Form.
I understand that at this time, the COVID-19 vaccine requires 2 doses given 21 - 28 days apart depending on the manufacturer. If this is my first dose of the COVID-19 vaccine, I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the vaccination series
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 uninsured, you must check the box below to attest that the following information is true and accurate:

I do not have any insurance, including but not limited to, Medicare, Medicaid, or any other private or government-funded benefit plan.

For uninsured patients, please select at least one of the following that you will bring with you to your appointment.
This is needed in order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program

Social Security Number

State identification number and state of issuance

Driver's license number and state of issuance

Pharmacy Use for Insurance Information

Signature of Patient or Authorized Representative______________________________ **Date:** ____________

Print Name of Representative and Relationship to Person Receiving Vaccine: ______________________________

*****PHARMACY USE ONLY*****

Vaccine	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	☐ 1st Dose ☐ 2nd Dose	☐ IM - L Arm ☐ IM - R Arm		☐ Moderna ☐ Pfizer			
COVID-19	☐ 1st Dose ☐ 2nd Dose	☐ IM - L Arm ☐ IM - R Arm		☐ Moderna ☐ Pfizer			

Pharmacist Print Name:______________________________ **Signature:** ______________________ **Date:** __________

Vaccinator Print Name:______________________________ **Signature:** ______________________ **Date:** __________

Vaccine administering provider suffix: ______________________________