HORSHAM Square PHARMACY
Wellness Center
575 HORSHAM RD UNIT C20 HORSHAM PA 19044
TEL 215-674-5050 FAX 215-957-5874
E-mail
covid@horshamsquarepharm.com
WWW.HORSHAMSQUAREPHARMACY.COM

FIRST NAME_____ **LAST NAME**_____ **M.I.** ____ **DOB**: _____-_____-_____

ADDRESS_____ **CITY**_____ **ST**_____ **ZIP**_____

CELL PHONE_____ **OTHER**_____**SEX**: □ MALE □ FEMALE

EMAIL:_____ **ETHNICITY** □ HISPANIC OR LATINO □NOT HISPANIC OR LATINO □ UNKNOWN

R**ACE**: □ AMERICAN OR ALASKAN NATIVE □ AFRICAN AMERICAN □PACIFIC ISLANDER □ ASIAN □ WHITE □ UNKNOWN

INSURANCE CARRIER ID# _____ **RXBIN** _____ **RXPCN** _____

RXGROUP_____ **RELATIONSHIP** □ SELF □ SPOUSE □ CHILD NAME OF INSURANCE _____

MEDICARE INFORMATION FOR 65 AND OLDER: REFER TO MEDICARE RED,WHITE AND BLUE CARE!

MEDICARE ID _____

IF YOU ARE UNINSURED, YOU MUST CHECK THE BOX 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 health benefit plan. In order to have your vaccine adm. Fee paid for the U.S. H.R.&S.A. Covid-19 Program for Uninsured Patients, please provide either a valid SS# or State ID#, or a driver's license #. SS#_____ DL#_____

DEPENDING ON WHAT WE HAVE IN STOCK YOU MAY RECIEVE THE MODERNA OR THE J&J SHOT. IF YOU HAVE A MEDICAL CONDITION THAT STATES YOU MUST HAVE ONE OVER THE OTHER PLEASE NOTATE HERE: _____

1. Do you have or have you had 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, runny nose, nausea, vomiting, or diarrhea?	**YES NO**
2. Have you tested positive for COVID-19 within the last 14 days?	**YES NO**
3. Have you ever had a severe allergic reaction in the past? Example: a reaction for which you were treated with an EpiPen or take to the hospital?	**YES NO**
4. If you answered YES to above please list what caused the reaction here:	
5. Are you allergic to Polyethylene Glycol or products containing Polyethylene Glycol?	**YES NO**
6. Was the severe allergic reaction related to receiving Polysorbate or products containing Polysorbate?	**YES NO**
7. Have you received any vaccines in the last 14 days?	**YES NO**
8. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days?	**YES NO**
6. Do you have a bleeding disorder or are you taking a blood thinner?	**YES NO**
7. For women, are you currently pregnant or breastfeeding?	**YES NO**

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Consent for services: I have been provided with the Vaccine Information Sheets or patient fact sheet corresponding to the vaccine that I am receiving. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to me or to the person named above for whom I am authorized to make the request.

Authorization to request payment: I do hereby authorize Horsham Square Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid, or the HRSA Covid-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

Disclosure of records: I understand that Horsham Square Pharmacy may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at Horsham Square Pharmacy, my Primacy Care Physician, my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or understand that Horsham Square Pharmacy will use and disclose my health information as set forth in their Notice of Privacy Practices (copy available in store).

Signature of patient to receive vaccine (or parent, guardian, or authorized representative)

_____ **Date:** _____

Name of parent, guardian, or authorized representative Relationship:

Vaccine Administration Information for Pharmacist/Nurse/Doctor Use Only:

ADMINISTRATION DATE _____ **VACCINE MODERNA OR J&J VIS DATE 12/20 .5 (ML) LOT #** _____

EXP DATE _____ **ROUTE** _____ **SITE L OR R**

ADMINISTERING IMMUNIZER NAME & TITLE_____