Paul Jones Drug

VACCINE CONSENT FORM

First name:	Middle Name:	Last Name:	Date of Birth:	Age:

Address:	City:	State:	Zip Code:

Ethnicity:
- ☐ African American
- ☐ American Indian
- ☐ Asian
- ☐ Caucasian
- ☐ Native Hawaiian/other Pacific Islander
- ☐ Prefer not to answer

Race:
- ☐ Hispanic/ Latino
- ☐ Non-Hispanic/Latino
- ☐ Unknown
- ☐ Prefer not to answer

Gender:

Phone Number:

Mother's Maiden Name:	SSN:	Primary Care Physician:

PATIENT QUESTIONS

1. Which Vaccine are you receiving today?
- ☐ Flu
- ☐ RSV
- ☐ YF
- ☐ Pneumonia (15/20/23)
- ☐ Shingrix
- ☐ Hepatitis
- ☐ Tdap
- ☐ Meningitis
- COVID-19
  - ☐ Pfizer
  - ☐ Moderna
  - ☐ Janssen

2. Are you feeling sick today?	☐ Yes	☐ No
3. Have you ever had an allergic reaction or a severe reaction to ANY vaccination or injectable medication: (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).	☐ Yes	☐ No
4. Have you ever had an allergic reaction to something other than a component of a vaccine or injectable medication? (This would include food, pet, environment, or oral medication allergies)	☐ Yes	☐ No
5. Have you received a vaccine in the last 30 days if so, which vaccine?_____	☐ Yes	☐ No
6. Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes	☐ No
7. Are you pregnant or breastfeeding?	☐ Yes	☐ No

Please answer the questions below if you are receiving a COVID-19 vaccination

8. Have you received a dose of COVID-19 vaccine?	☐ Yes	☐ No
• **If you have received a dose of COVID-19 vaccine before:** ○ **Vaccine manufacturer (ex: Pfizer, Moderna, Janssen):_____** ○ **Date of last COVID vaccine:_____** ○ **Number of COVID-19 Booster doses recieved:_____**		
9. Have you ever had a positive test for COVID-19 or has a healthcare provider ever told you that you had COVID-19?	☐ Yes	☐ No
10. 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.)	☐ Yes	☐ No
11. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressant drugs or therapies?	☐ Yes	☐ No

Insurance and Reporting

If Uninsured: Obtain one of the following:	**If Medicaid:**	**If Medicare:**	**If Commercial insurance:**
☐ Social Security Number: _____ ☐ Driver's License Number: _____ State of Issuance: _____	☐ Medicaid ID number _____ State of Issuance: _____	☐ Medicare ID: _____ ☐ Social Security Number _____	Rx BIN:_____ Rx PCN:_____ Rx Group:_____ Cardholder ID number: _____

I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization, a copy of which I was provided with this consent and release. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this consent and release.

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

Pharmacy Use Only

Vaccine	Dose in Series	Route	Date	Manufacturer	Lot Number	Expiration	Name/signature of certified vaccine administrator
		☐ IM-L Arm ☐ IM- R Arm					