LTC facilities only: *Please fill out one form per resident and return to pharmacy on the scheduled date of your vaccine clinic. Be sure to include the patient's name and date of birth at the top of this form. All other information can be left blank if you are submitting patient demographics or face sheets with each consent form. Please include patient insurance information (i.e.,* ***Medicare Part B number****) also.*

COMMONSHARE RX

1602 Skipwith Rd #201 Richmond, VA 23229
Phone: 804-416-6255 | Fax: 804-967-3999
info@commonsharerx.org

VACCINE CONSENT FORM

Last Name	First Name	MI	Date of Birth	Male ☐ Female ☐
Street Address		City	State	Zip
Phone Number	Email	Primary Care Provider		
Health Insurance (ex: Medicare, etc)	Member ID or SSN	Rx BIN #	Rx PCN	Rx ID # / Rx group #

	YES	NO	DON'T KNOW
Do you feel sick today?			
Are you allergic to any medications or food products? If yes, please list:			
Have you ever had a *severe* reaction after receiving a vaccination or injection?			
Are you currently in quarantine for COVID-19 exposure?			
Have you received other vaccine(s) within the past 28 days? If yes, please list:			
Do you have a bleeding disorder or are you taking a blood thinner?			
Do you take high-dose steroids, have medications/conditions that suppress your immune response, or had recent antibody treatment? If yes, please explain:			
If you are a woman: Are you currently pregnant or breastfeeding?			

*********IF RECEIVING A COVID-19 VACCINE**, also complete the following: ***********

When was your last COVID-19 dose?

All COVID-19 boosters for ages 12+ given after August 2022 are **updated** "bivalent" boosters.
Have you ever received this updated booster? If so, when?

Do you *prefer* **PFIZER** or **MODERNA** vaccine?
*vaccine manufacturer supply based on availability

I have reviewed the questions above and answered to the best of my ability with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization Fact Sheet provided to me today. I understand the benefits and risks associated with the vaccine. The vaccine listed should be given to the person named above for whom I am authorized to make this request. I agree to allow Commonshare to bill my insurance which will include disclosure of personal and medical information.

Signature of Parent/Guardian/Patient	Date

Healthcare Providers Only:

Vaccine Name/Manufacturer	Lot Number	IM Site LD ☐ RD ☐	Administrator	Date