*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.*

2026-A Dabney Rd
Richmond, VA 23230
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**	**Driver's License #/State/Expiration Date OR SSN**		
Race/Ethnicity	**Primary Care Provider**	**Medical conditions (ex: obesity, diabetes, smoker, etc)**		

Health Insurance (ex: Medicare, etc)	**Member ID**	**Rx BIN #**	**Rx PCN**	**Rx ID #**	**Rx group #**

	YES	NO	Don't know
Do you feel sick today?			
Do you have any severe allergies to medications or food? if yes, please list:			
Have you ever had a reaction after receiving a vaccination or injection?			
Have you tested positive for COVID-19 in the last 14 days/currently in quarantine for COVID-19 exposure?			
Have you received any other vaccine within the past 28 days?			
Do you have a bleeding disorder or are you taking a blood thinner?			
Do you have a condition that may weaken your immune system (ex: cancer, leukemia, HIV/AIDS, transplant)?			
Do you take high-dose steroids or other medications that may suppress your immune response (ex: Humira®, Enbrel®, Remicade®, antivirals, anticancer, radiation treatment)?			
If you are a woman: Are you currently pregnant or breastfeeding?			

Please complete the following if receiving a COVID-19 vaccine:

Have you been treated with antibody therapy for COVID-19?
How many doses of COVID-19 vaccine have you received?
Which vaccine manufacturer did you receive (ie. Pfizer, Moderna, etc)?
When was your last COVID-19 dose?

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 have been given the opportunity to review the Notice of Privacy Practice at the time of vaccination, and acknowledge this document is available at any time for future review. I also attest to being truthful and of sound mind regarding my insurance coverage status. I agree to allow Commonshare to bill my insurance or seek reimbursement from HRSA CARES Act funding which will include disclosure of personal and medical information.

Signature of Parent/Guardian/Patient	**Date**

Healthcare Providers Only:

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