Mills Family Rx Pharmacy
Compounding Center and Gift Shoppe
2994 S Church Street Murfreesboro, TN 37127
Phone: (615)- 895- 1641

Covid-19 Immunization Consent Form

Name (last, first):_____ Date of Birth:_____

Phone:_____ Address:_____

City:_____ State:_____ Zip:_____

Email:_____ Gender: ☐ Male ☐ Female ☐ Othe

Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaskan Native ☐ Native Hawaiian or other Pacific Islander ☐ Other ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown

Allergies:_____ ☐ No known allergies

Please answer the following questions to the best of your knowledge and understanding:

1. Are you sick today? (fever, chills, cough, shortness of breath, fatigue, muscle/body aches, headache, new loss of taste/smell, sore throat, congestion, runny nose, nausea/vomiting/diarrhea?) ☐ Y ☐ N

2. Have you been exposed to Covid-19 in the past 14 days? ☐ Y ☐ N

3. Have you received any vaccine in the past 14 days? ☐ Y ☐ N

4. Have you ever had a severe reaction to any vaccine? ☐ Y ☐ N

   - If yes: Allergy/reaction: _____
     Vaccine/ingredient: _____

5. Have you ever had the Covid-19 vaccine before? ☐ Y ☐ N

6. Do you have any allergies to a vaccine component? ☐ Y ☐ N

7. Have you ever tested positive for Covid-19 ☐ Y ☐ N

   - If yes: Date of positive test:_____
     Did you receive monoclonal antibodies or convalescent plasma in treatment of your Covid-19 infection?: ☐ Y ☐ N

8. Are you pregnant or breastfeeding? ☐ Y ☐ N

9. Do you have any of the following health conditions (please circle)?
Cancer, chronic kidney disease, COPD, heart failure, coronary artery disease, cardiomyopathies, history of organ transplant, BMI ≥30, sickle cell anemia, smokers, type 2 diabetes, pregnancy, none of the above

I am requesting that the Covid-19 vaccine be administered to me. I have had the opportunity to ask questions regarding the vaccine and understand the risks and benefits and choose to assume that risk. As with all medical treatments, there is no guarantee that I will not experience any adverse side effects from the vaccine. I fully release and discharge this pharmacy from any liability for illness, injury, loss and damage. I am aware that, to provide protection against the virus that causes Covid-19, two doses of this same vaccine may be required. I acknowledge that I may receive a reminder for a second dose by text, phone call, or email. I confirm that the information provided herein is correct and complete to the best of my knowledge and belief.

Signature:_____ Date:_____

(Form continued on back)

Insurance Information
Do you have medical insurance? ☐ Y ☐ N Medical insurance provider:_____ ID number:_____ Group number:_____ Plan contact phone number:_____ Pharmacy insurance provider:_____ Rx ID number:_____ Rx BIN number:_____ Rx PCN:_____ Rx Group number:_____ Plan contact phone number: _____

For pharmacy use only		
Covid-19 Vaccine Manufacturer:		
☐ Moderna	☐ Pfizer	☐ Other:_____
Dose: 0.5 mL	Dose: 0.3 mL	Dose: _____
EUA date: 12/2020	EUA date: 12/2020	EUA/VIS date:_____

Lot number:_____ Expiration date:_____ NDC:_____

Administration site: ☐ Right deltoid ☐ Left deltoid Dose #:_____ of 2

Pharmacist/ Intern signature:_____ Administration Date:_____

Pharmacist/ Intern name:_____ (if intern) Supervising pharmacist:_____