Name * (Last, First) _____ Date of Birth * (MM/DD/YYYY) _____

Gender *

- o Female
- o Male
- o Other

Address *

Line 1_____ City_____

Line 2_____ Country_____

State/Province_____ Zip Code_____

Phone *(xxx-xxx-xxxx)_____

Primary Care Provider Name: _____

Emergency Contact Name, Relation, Phone Number *_____

Phase 1B - Tier 1 Worker Information: Protecting those who keep us safe and help during emergencies (please select one if applicable)

- o First Responders
- o Non-Patient Facing Public Health Infrastructure
- o Emergency Management and Public Works
- o Emergency Services Sector

Phase 1B - Tier 2 High-Risk Individuals: Protecting those who are at increased risk for severe illness (please select one if applicable)

- o Anyone aged 65 and older
- o Any Adult with the following conditions: Cancer, Chronic Kidney Disease, COPD, Intellectual &/or developmental disabilities such as Down Syndrome, Heart Conditions (such as heart failure, coronary artery disease, or cardiomyopathies), Immunocompromised state from solid organ transplant, Severe Obesity (BMI>40), Pregnancy, Sickle Cell Disease, &/or Type 2 Diabetes Mellitus

Have you ever received a dose of COVID-19 Vaccine? *

- o Yes
- o No

If so, date of first dose? (MM/DD/YYYY) _____

Date of second dose? (MM/DD/YYYY) _____

Have you ever had an allergic reaction to: (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)

- A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures *
  - o Yes
  - o No
- Polysorbate *
  - o Yes
  - o No
- A previous dose of COVID-19 Vaccine *
  - o Yes
  - o No

Have you ever had an allergic reaction to another vaccine (other than COVD-19 vaccine) or an injectable medication? *

- o Yes
- o No
- o Don't know

Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies. *

- o Yes
- o No
- o Don't know

Have you received any vaccine in the last 14 days? *

- o Yes
- o No
- o Don't know

Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19? *

- o Yes
- o No
- o Don't know

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) *

- o Yes
- o No
- o Don't know

Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? *

- o Yes
- o No
- o Don't know

Do you have a bleeding disorder or are you taking a blood thinner? *

- o Yes
- o No
- o Don't know

Are you pregnant or breastfeeding? *

- o Yes
- o No
- o Don't know

Consent (initial each line below after reading and signing) *

I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet (insert link to EUA for the vaccine the pharmacy provides), a copy of which I was provided with this Consent Form. 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 the Consent Form. ____

I understand that at this time, the COVID-19 vaccine requires 2 doses given 21-28 days apart depending on the manufacturer. If this is my first dose of the COVID-19 vaccine, I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the vaccination series. ____

I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur. ____

I understand that I will be receiving the vaccination at no cost to me. ____

If insured, please bring in your prescription and medical insurance cards for your vaccine appointment. I authorize the pharmacy to bill my insurance on my behalf for the immunization - understanding I will not incur any costs. ____

If uninsured, you must mark below to attest that the following information is true and accurate:

- o I do not have any insurance, including but not limited to, Medicare, Medicaid, or any other private or government-funded benefit plan.

For uninsured patients, please select one of the following that you will bring with you to your appointment. This is needed in order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program.

- o Social Security Number
- o State identification number and state of issuance
- o Driver's license number and state of issuance

Signature of Person to Receive Vaccine & EUA/VIS: _____

Date (MM/DD/YYYY) _____