/

Appt. Time

CUSTOMER
COVID-19 VACCINE ADMINISTRATION FORM

MED CENTER PHARMACY

SECTION 1 – INFORMATION ABOUT THE PERSON RECEIVING THE VACCINE

Name: _____ Date of Birth: _____/_____/_____ Age:_____ Phone: (_____)_____

Address:_____ City:_____ County: _____, TX Zip Code: _____

E-mail_____

Have you ever received a COVID-19 vaccine? Yes No If yes, manufacturer name: _____ Date received: _____

Social Security Number: _____-_____-_____ (this is needed by the federal government if you do not have health insurance)

Race: American Indian r Alaska Native Asia Black or African American Native Hawaiian or Other Pacific Island White Other Prefer not to disclose

Ethnicity: Hispanic Non-Hispanic Prefer not to disclose

MedCenter Pharmacy Will contact your primary care provider informing them of vaccine(s) given today using the information provided below

Primary Care Provider Name: _____ Phone: (_____)_____ Fax: (_____)_____

Gender: Male Female Other

SECTION 2ª – QUESTIONS TO DETERMIN VACCINE ELIGIBILITY (circle Yes or No)

1. Do you currently have COVID-19 or have you had it in the last 90 days?	YES	NO
2. Are you sick today or do you have any of the symptoms: fever, chills, shortness of breath, body aches, loss of taste/smell?	YES	NO
3. Have you ever had a anaphylactic reaction, serious allergic reaction, or any other serious reactions to a vaccine?	YES	NO
4. Have you had any vaccinations in the past 14 days?	YES	NO

SECCIÓN 2B -- CONSIDERACIONES CLÍNICAS (circule Sí o No)

5. Are you pregnant or breastfeeding?	YES	NO
6. Are you immunocompromised or taking medications that affect your immune system?	YES	NO
7. Are you taking blood-thinning medications or do you have a bleeding disorder?	YES	NO

SECTION 3 – PLEASE READ CAREFULLY AND ACKNOWLEDGE WHERE APPROPRIATE

I hereby give my consent to MedCentery Pharmacy to administer the vaccine(s) (the "Services") I have requested below.

With my initials, I certify that:

_____ I am: (i) the Patient and at least 18 years of age; (ii) the parent or guardian of the minor Patient; or (iii) the legal guardian of the Patient; or (iv) a person authorized under the law of another state or a court order to consent for a child; OR

_____ The persons identified under (ii), (iii), or (iv), in the preceding sentence are unavailable and I have authority to consent to the immunization of the child because I am a (i) grandparent; (ii) adult brother or sister; (iii) adult aunt or uncle; (iv) stepparent; or (v) another adult who has actual care, control, and possession for the child and has written authorization to consent for the child form a parent, managing conservator, guardian, or other person who, under the law of another state or a court order, may consent for the child; additionally, I certify that I do not have knowledge of any express refusals or withdrawn authorizations of consent and have not been told not to give consent for the child.

I understand that any protected Health Information ("PHI") I provide MedCenter Pharmacy will only be used or disclosed by MedCenter Pharmacy in accordance with MedCenter Pharmacy's Health Insurance Portability and Accountability ACT ("HIPAA") Notice of Privacy Practices. By signing below, I acknowledge receipt of such HIPAA Notices of Privacy Practices and consent to the uses and disclosures of PHI described therein. While MedCenter Pharmacy reserves the right to not do so, I consent to MedCenter Pharmacy reporting my immunization information to the State Immunization Registry. Should MedCenter Pharmacy elect to report my immunization history to the Texas central immunization registry, ImmTrac, I further understand that my immunization information may be accessed by other health care providers, educators, public health representatives, state agencies and certain insurance payers. I further authorize MedCenter Pharmacy to (1) release my medical or other information to my healthcare professionals, Medicare, Medicaid, or other third-party payers as necessary to effectuate care of payment or otherwise, (2) submit a claim to my insurer for the below requested items and services, and (3) request payment of authorized benefits be made on my behalf to MedCenter Pharmacy with respect to the below requested items and services.

NOT A SUBSTITUTE FOR A PHYSICIAN

I understand that MedCentery Pharmacy representatives are not phy7sicians trained to diagnose and treat medical problems. I acknowledge that the administration of Services does not constitute, and should not be interpreted as, medical advice or opinions substituting for the advice of a physician. I understand that the administration of Services does not create a doctor-patient relationship between myself and MedCenter Pharmacy. I agree to consult a physician if I require medical advice or services at any time.

RELEASE, IMDEMNITY AND DISCLAIMER

I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s), including novel COVID-19 vaccine(s). I understand the risks and benefits associated with novel vaccine(s) and elect to receive a COVID-19 vaccine. I also acknowledge that I have had a change to ask questions and that such questions were answered to my satisfaction I additionally acknowledge that I have received a copy of the MedCenter Pharmacy notice of Privacy. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering health care provider. I understand that in the course of the requested vaccine administration, a MedCenter Pharmacy representative could possibly be exposed to my blood or bodily fluids. In such event, I agree to review and execute the "MedCenter Pharmacy Post-exposure Consent for Testing" form.

On behalf of myself, my heirs and personal representatives, I further hereby WAIVE, RELEASE, and AGREE TO INDEMNIFY, DEFEND AND HOLD HARMLESS (including for costs and attorney's fees) MedCenter Pharmacy, its staff, agents, employees and corporate affiliates from any and all liabilities or claims whether known or unknown arising our of, in connection with, or in any way related to the administration of COVID-19 vaccine(s) and related services, even should such damages or losses result from MedCenter Pharmacy's negligence.

I have received, read and/or had explained to me the Emergency Use Authorization fact sheet or the Vaccination Information Statement for the vaccine I have elected to receive.

Patient Signature: _____ **Date:** _____
(Parent or Legal Guardian, if minor)

SECTION 4 -- PHARMACY USE ONLY

Insurance Carrier Name: _____ ID: _____ GRP: _____BIN_____

PCN_____ Policy Holder Name (if different): _____ Policy Holder Date of Birth: _____

SECTION 5 – MEDICARE PART B USE ONLY

Medicare Part B Authorization Form

Statement to Permit Assignment of Medicare Benefits

- I understand that I am giving **MedCenter Pharmacy** permission to ask for Medicare payments for my Medicare care, including supplies and equipment.
- I understand that Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare and the companies that handle Medicare payment requests.
- I understand that the Centers for Medicare & Medicaid Services (CMS) is the government's Medicare agency. I understand that a photocopy of this release is a valid as the original document. Furthermore, I understand that I am responsible for paying any deductible or coinsurance amounts.
- Therefore, I asked that payments of authorized Medicare benefits be made to either me or on my behalf to **MedCenter Pharmacy** for any services or items furnished to me by **MedCenter Pharmacy**. I authorize any holder of medical or other information about me to release such information to the Centers for Medicare & Medicaid Services (CMS) and its agents as needed to determine these benefits or benefits for related services.

Name: _____ HICN: _____

Signature:_____ Date: _____

SECTION 6 – PHARMACY USE ONLY Temperature checked by (Partner initials): _____

Vaccine	Amount Administered	Manufacturer	Dose # (circle)	Route	Lot Number	Exp Date	Site of Administration
COVID-19	0.3ML	PFIZER	1 or 2	IM			LA RA
COVID-19	0.5ML	MODERNA	1 or 2	IM			LA RA

*RD - Right Deltoid, LD - Left Deltoid, RA - Right Arm, LA - Left Arm

Vaccine Information

Pfizer – 2 shots series at 0 to 21 days, authorized for 16 years of age and older.
Moderna – 2 shots series at 0 to 28 days, authorized for 18 years of age and older.

MedCenter Pharmacy Location	To be Completed by Pharmacist	Technician Immunizer (if applicable)
MedCenter Pharmacy 1419 East Bustamante St. Laredo, TX 78041	_____ Luis Martinez Jr., R.Ph. Lic# : 30109 NPI : 1265096580 _____ Judith Alexander, R.Ph. Lic# : 23520 NPI : 1184287880 _____ Karla Garza, Pharm.D. Lic# : 49080 NPI : 1396308219	Immunizer Initials _____ Signature: _____ – TX Registration #: _____

	Date of Immunization: _____ Next Dose Due Date: _____