VACCINE ADMINISTRATION CONSENT FORM

Vaccine Needed: COVID-19 ☐ INFLUENZA ☐

MED CENTER Rx

SECTION 1 – INFORMATION ABOUT THE PERSON RECEIVING THE VACCINE

Full Name: _____ Date of Birth: _____/_____/_____ Phone: (____)_____

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

E-mail_____

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

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: (____)_____

SECTION 2A – QUESTIONS TO DETERMINE VACCINE ELIGIBILITY (circle Yes or No)

1. In the last 10 days, have you or someone with whom you've been in close contact been diagnose with Covid-19?	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? Are you taking medication?	YES	NO
3. Have you ever had an anaphylactic reaction, serious allergic reaction, or any other serious reactions to a vaccine?	YES	NO
4. Do you have a seizure disorder, brain disorder, Guillan-Barre Syndrome, or nervous system disorder?	YES	NO
5. Do you have any long-term health conditions or a weakened immune system?	YES	NO
6. Do you have any allergies to medications, food or latex? (ex. Egg, bovine gelatin, gentamicin, polymyxin, phenol, yeast)	YES	NO
7. During the past year, have you received blood or blood products or been given immune (gamma) globulin?	YES	NO
8. Are you taking blood-thinning medications or do you have a bleeding disorder?	YES	NO
9. **FOR WOMEN:** Are you pregnant or breastfeeding or is there a chance you could become pregnant in the next month?	YES	NO

SECCIÓN 2B – FOR COVID VACCINE ONLY

10. Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies or convalescent plasma)?	YES	NO
11. Have you ever received a COVID-19 vaccine? If yes, Manufacturer Name:_____ Date:_____	YES	NO

12 . **Race:** ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Other ☐Prefer not to disclose

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Prefer not to disclose

Gender: ☐Male ☐Female ☐Other

SECTION 3 – PLEASE READ CAREFULLY AND ACKNOWLEDGE WHERE APPROPRIATE

I hereby give my consent to MedCenter 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 phy7siclans 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 out 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)