Pre-Vaccination Checklist for COVID-19 Vaccines

Phone (609) 893-4700 Fax (609) 893-7380

POWER'S PHARMACY

SECTION A Please print clearly.

First name: _____ **Last name:** _____

Date of birth: _____ **Age:** _____ **Gender:** ☐ Female ☐ Male **Phone:** _____

Home address: _____ **City:** _____

State: _____ **ZIP code:** _____ **Email address:** _____

Social Security Number or Medicare Number : _____

Insurance _____ **RX Bin#** _____ **RX PCN#** _____ **RX GROUP#** _____ **ID#** _____

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

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ethnicity

SECTION B *The following questions will help us determine your eligibility to be vaccinated today.*

1.	Do you feel sick today?	☐ Yes ☐ No ☐ Don't know
2.	Have you been diagnosed with or tested positive for COVID-19 in the last 14 days?	☐ Yes ☐ No ☐ Don't know
3.	In the past 14 days have you been identified as a close contact to someone with COVID-19?	☐ Yes ☐ No ☐ Don't know
4.	Have you ever recieved a dose of COVID-19 vaccine?	☐ Yes ☐ No ☐ Don't know
5.	Do you have a history of allergic reaction or allergies to latex, medications, food or vaccines (examples: polyethylene glycol, polysorbate, eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list: _____	☐ Yes ☐ No ☐ Don't know
6.	Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	☐ Yes ☐ No ☐ Don't know
7.	Do you have Derma Fillers?	☐ Yes ☐ No ☐ Don't know
8.	Have you received any vaccinations or skin tests in the past eight weeks? If yes, please list: _____	☐ Yes ☐ No ☐ Don't know
9.	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐ Yes ☐ No ☐ Don't know
10.	Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes ☐ No ☐ Don't know
11.	For women: Are you pregnant or considering becoming pregnant in the next month?	☐ Yes ☐ No ☐ Don't know
12.	Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies or convalescent plasma)?	☐ Yes ☐ No ☐ Don't know

SECTION C

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to the pharmacy and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the EUA Fact Sheet on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees 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 the vaccine(s) listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Centers for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the applicable Provider: (a) the disclosure of my vaccination information by the applicable Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and, to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies, State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws or federal law may permit certain disclosures of my vaccination information to or through the State HIE or to Government Agencies as required or permitted by law. I further authorize the applicable Provider to: (a) release my medical or other information, including any communicable disease (including HIV) and mental health information, to, or through, the State HIE or Government Agencies to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice. Pharmacy or its affiliates may contact you, including by autodialed and prerecorded calls and texts, at any time, using the contact information provided in your patient record regarding health and safety matters, such as vaccine reminders.
By signing below I certify that I am eligible to receive this vaccine as per all local, state and CDC guidelines.

Patient signature: _____ Date: _____
(Parent or guardian, if minor)

If uninsured: I attest that I do not have any medical or pharmacy insurance. ☐ Yes

Drivers license/State ID number (circle one) _____ Issuing state: _____ Initial here: _____

SECTION D **HEALTHCARE PROVIDER/PHARMACIST ONLY**

Complete AFTER vaccine administration

Administration Date	Manufacturer	Vaccine Lot#	Vaccine Expiration	Site of Administration	

Clinician name (print): _____ **Clinician signature:** _____

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