Vaccine Administration and Consent Form

Bring this form, all insurance card (s) and a government-issued photo ID to the vaccine location.

Name:	**Phone:**	**DOB:**	**Weight (lb):**
Address:		**City:**	**State:**

Primary Care Physician Name:	**Primary Care Physician Phone #:**
Vaccine(s) requested:	**Have You completed primary doses (2) of Covid-19 Vaccine** **Yes _____ No _____**

Sex (Gender assigned at birth) ☐ Female ☐ Male	**Race** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other ☐ Pacific Islander ☐ White ☐ Other Asian ☐ Unknown ☐ Other Nonwhite ☐ Other Pacific Islander	**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Insurance Information:

Rx BIN:
PCN:
Group:
ID:
Relationship to Cardholder:

Medicare (Red, White, Blue Card):

Questions below will help us determine your eligibility to be vaccinated today.	Yes	NO	Don't Know
1. Are you sick or do you have a fever?			
2. Have you had a severe allergic reaction to food, pet, venom, environmental or oral medication?			
3. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?			
4. Have you had an allergic reaction to polyethylene glycol (PEG), polysorbate or a previous dose of COVID-19 vaccine?			
5. Are you a male between ages 12 and 29 years old?			
6. Do you have a history of myocarditis or pericarditis?			
7. Do you have a history of Guillain-Barré syndrome (GBS)?			
8. Are you a female between ages 18 and 49 years old?			
9. Do you have a history of heparin-induced thrombocytopenia (HIT)?			
10. Do you have a bleeding disorder or are you on a blood thinner?			
11. Are you currently pregnant or breastfeeding?			
12. Do you have a history of using a dermal filler?			
13. Do you have a weakened immune system (ie. HIV infection, cancer) or take immunosuppressive drugs/therapies?			
14. Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?			
15. Have you had COVID-19 and were treated with monoclonal antibodies or convalescent serum?			

- I understand the benefits and risks of the vaccination(s) as described in the Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release. I request the vaccine(s) be given to me or to the person named below, a minor for whom I represent that I am authorized to sign this Consent and Release.
- I have received a copy of the notice of Privacy Practices. I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the Pharmacy and my rights with respect to my health information, including reporting to the State Vaccination Registry and/or local or state Department of Health, federal Department of Health and Human Services, and the Center for Disease Control and Prevention.

I hereby certify that the above information I provided is true and correct to the best of my knowledge.

Patient/Legal Guardian Name: Signature: Date:

The following is to be completed by the health care provider ONLY.

Vaccine Administrator Name (Print):	Professional Designation:	Signature:
Intern Name (Print):	Administration Date/Date Fact Sheet/Immunization Card Given:	

Vaccine	Lot #	Exp. Date	Manufacturer	NDC	Dose #	Dosage mL	Site	Route	RPh Init.
							LA RA	IM	
							LA RA	IM	
							LA RA	IM	

Pfizer Bivalent Vaccine Fact Sheet

Moderna Bivalent Vaccine Fact Sheet

Influenza Vaccine Information Sheet

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