Last Revised: 04/2023

# Informed Consent for COVID-19 Vaccination

**Section A (Patient Information)** ***please print clearly***

Last Name: _____ First Name: _____ MI: _____ Gender (M/F): _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: (_____) - _____ - _____ Birth Date: _____/_____/_____ POA (Y/N): _____

Medicare #: _____ OR Insurance Name: _____ ID: _____ Group: _____

Phys Last Name: _____ Phys First Name: _____ Phone: (_____) - _____ - _____

**Section B (Power of Attorney Information, *if applicable*)** ***please print clearly***

Last Name: _____ First Name: _____ Phone: (_____) - _____ - _____

**Section C**

I certify that I am: (i) the patient and at least 18 years old, (ii) the legal guardian of the patient, (iii) eligible to receive this vaccination per ACIP guidelines. I hereby give my consent for O'Connell Pharmacy Pharmacist, technician, or the intern under the direct supervision of a pharmacist to administer the COVID-19 vaccine requested. I understand the risks and benefits associated with the vaccine and have received, read and/or had explained to me the Emergency Use Authorization Form associated with the COVID-19 Vaccine I am receiving. I hereby release and hold harmless O'Connell Pharmacy and its employees from any and all liabilities or claims known or unknown in any way related to administration of the vaccine. I consent to O'Connell Pharmacy reporting the vaccination information to the state's immunization registry and releasing my medical information to my healthcare professionals, Medicare, Medicaid or other 3rd party payer as necessary to facilitate payment. I further agree to be fully financially responsible for any due amounts, including copays, coinsurance, and deductibles.

**Patient Signature (or legal guardian):** _____ **Date:** _____

**Section D** ***determines patient eligibility to receive vaccination***

**Previous COVID-19 Vaccine Received:** ☐ **YES** ☐ **NO** **If Yes, Brand Name:** _____

Do you have one or more severe allergies, or three or more general allergies? _____

☐ YES ☐ NO ☐ DON'T KNOW

Have you ever had a reaction to receiving a vaccination? _____

☐ YES ☐ NO ☐ DON'T KNOW

Do you have a seizure, or a brain or other nervous system problem? _____

☐ YES ☐ NO ☐ DON'T KNOW

Do you have a bleeding disorder, or are you currently taking a blood thinner (except Aspirin)? _____

☐ YES ☐ NO ☐ DON'T KNOW

Do you have an immunocompromising condition as defined under the FDA or EUA guidelines? _____

☐ YES ☐ NO ☐ DON'T KNOW

Are you breastfeeding, currently pregnant or planning on becoming pregnant in the next month? _____

☐ YES ☐ NO ☐ DON'T KNOW

Have you received immunoglobulin, COVID-19 Vaccine, or any other vaccination in the last four weeks? _____

☐ YES ☐ NO ☐ DON'T KNOW

**Do you feel sick today, including any upper respiratory issues *(Pharmacy to Ask on Day of Vaccination)*?** _____

☐ **YES** ☐ **NO** ☐ **DON'T KNOW**

**Have you been diagnosed with or been in contact with any communicable disease in the last 21 days?** _____

☐ **YES** ☐ **NO** ☐ **DON'T KNOW**

**Section E** ***for pharmacy use***

**Name/Title of Administering/Authorizing Pharmacist**: _____ **Date:** _____

| Vaccination Given | Lot # | Exp Date | Mfgr | Dose | Route | Site | EUA Given |
|---|---|---|---|---|---|---|---|
| COVID-19 Bivalent 12+ | | / / | | | IM | L R (Deltoid) | ☐ |
| | | | | | | | |
| COVID-19 Bivalent 5-11 | | / / | | | IM | L R (Deltoid) | ☐ |
| | | | | | | | |

**Date Billed:** _____/_____/_____ **Date Recorded in WIR:** _____/_____/_____

***This form constitutes pharmacist consent of an EUA order per FDA and ACIP Guidelines***