Bell Pharmacy

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COVID-19 Vaccination Consent Form

Last Name	First Name	MI	Date of Birth	☐ Male ☐ Female
Address	City		State	Zip
Phone Number	Email			

Is this the patient's □ first OR □ second dose OR □ third dose of the COVID-19 vaccination?

Requested vaccine: □ Moderna OR □ Pfizer

Insurance Information

Prescription Insurance:

Is the patient the primary cardholder? □ Yes □ No
If No, include primary cardholder's date of birth: _____

Prescription Plan Name	Cardholder ID	Rx Group ID	BIN	PCN

Medical Insurance:

Is the patient the primary cardholder? □ Yes □ No
If No, include primary cardholder's date of birth: _____

Medical Plan Name	Cardholder ID	Group ID	Payer ID

Medicare Fields:

Is the patient aged 65 years or older or Medicare Eligible? □ Yes □ No

Medicare Part A/B ID Number (MBI): _____

Note: MBI is required for all patients aged 65 and older, or Medicare eligible. Refer to your Medicare Red, White, and Blue card

Uninsured:

If uninsured, you must check the box below to attest that the following information is true and accurate. Please also provide the information listed on the line below.

□ I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government-funded health benefit plan.

In order to have to your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, please provide a valid social security number, state identification number and the state of issuance OR a driver's license and the state of issuance.

_____

Social Security Number OR State Identification Number & State OR Driver's License & State

Race (circle answer): Asian American Indian or Alaska Native White
Black or African American Other Prefer not to specify

Ethnicity (circle answer): Hispanic or Latino Not Hispanic Prefer not to specify

Screening for Vaccination Eligibility

1. Are you currently pregnant or breast feeding?	Yes	No
2. Do you have an allergy to medication, foods, or any vaccines (eggs, gelatin, neomycin, gentamycin, latex, aluminum, preservatives, baker's yest, etc.)?	Yes	No
3. Have you ever had a seizure, brain disorder, or Guillain-Barre Syndrome?	Yes	No
4. Have you had a severe allergic reaction (ex. anaphylaxis, trouble breathing) to any vaccine or injectable therapy, or a history of anaphylaxis due to any cause?	Yes	No
5. Have you received any other vaccine within the past 14 days or are scheduled to receive any vaccine in the next 14 days?	Yes	No
6. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?	Yes	No
7. Are you currently sick? Are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc?	Yes	No
8. Do you have a bleeding disorder or are you taking a blood thinner?	Yes	No
9. Have you tested positive for COVID-19 in the last 14 days?	Yes	No
10. Are you currently in quarantine for COVID-19 exposure?	Yes	No

Consent for Vaccination

I have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if my vaccine requires two doses, I will need to be administered (given) two doses of this vaccine for it to be effective. I have had a chance to ask questions, which were answered to my satisfaction, and ensured the patient for whom I am authorized to provide consent was also given a chance to ask questions). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including monies or benefits from my health plan, Medicare or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

_____

Patient/Guardian (Signature) Print Name Date/Time

_____

Relationship to Patient (if other than patient)

Area Below Completed by Vaccinator

Vaccine Name	Date Given	Lot Number	Administration Site	Vaccinator
☐ Moderna ☐ Pfizer			☐ Left Deltoid ☐ Right Deltoid	
☐ Moderna ☐ Pfizer			☐ Left Deltoid ☐ Right Deltoid	
☐ Moderna ☐ Pfizer			☐ Left Deltoid ☐ Right Deltoid	