PATRICK SQUARE PHARMACY

COVID-19 Vaccine Administration Consent Form

Last Name	First Name	M.I.	Gender
Primary Care Physician	Date of Birth	Age	Race/Ethnicity
Street Address	Phone		
City	County	State	Zip

VACCINATION AND HEALTH-RELATED INFORMATION

Are you feeling sick today?	☐ Yes	☐ No
Have you ever received a COVID-19 vaccination? If yes, date given_____Manufacturer_____	☐ Yes	☐ No
Have you received another vaccine in the last 14 days?	☐ Yes	☐ No
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID 19?	☐ Yes	☐ No
Have you ever had a severe allergic reaction to something? For example, were treated with epinephrine or EpiPen, or for which you had to go to hospital?	☐ Yes	☐ No
Have you had a life-threatening reaction to any injectable medication, including a COVID-19 vaccine, or to a vaccine component (examples: eggs, thimerosal, gelatin, neomycin, phenol, or bovine protein)? Yes, list_____	☐ Yes	☐ No
Have you ever had a seizure or any other brain or other nervous system problem (i.e., Guillain-Barré Syndrome) after receiving a vaccine?	☐ Yes	☐ No
Do you have long-term health problems with: (Heart Disease, Lung Disease, Asthma, Kidney or Liver Disease, Metabolic Disease, such as Diabetes, Bleeding disorder or take a blood thinner)	☐ Yes	☐ No
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
For Women: Are you pregnant or considering becoming pregnant in the next three months, or currently nursing?	☐ Yes	☐ No

I have read the Emergency Use Authorization (EUA) Fact Sheet or the VIS about the COVID-19 virus and vaccine. I understand the benefits and risks of the COVID-19 vaccine. I give permission for the above-named patient to receive the vaccine indicated. I authorize billing insurance for the vaccine administration fee for the vaccine provided.

Signature or Signature of Representative _____Date_____

(To Be Completed by Vaccine Administrator)

Date Vaccine and VIS Given	VIS or EUA Fact Sheet Date (circle one)	Clinical Site Patrick Square Pharmacy	NCES #

Vaccine Given: ☐ Janssen ☐ Moderna 1st. ☐ Moderna 2nd ☐ Moderna Booster ☐ Pfizer Booster

Manufacturer	Lot Number	NDC #	Expiration Date	Site of Injection: LA RA	Route IM

Pharmacist Signature	Date