Family Pharmacy Clinical Services

COVID-19 Vaccination Consent Form

Which Dose? ☐FIRST DOSE ☐SECOND DOSE (Date of first dose_____ Brand_____)

Patient Name: _____ **Date of Birth:** ____/____/_____
First MI Last MM/DD/YYYY

Sex: ☐ **M** ☐ **F** **Race/Ethnicity:** _____ **Phone:** (_____)_____

Address: _____
Street or P.O. Box City State Zip

Insurance Carrier: _____**Rx ID#**: _____ **Rx Group#:** _____

Rx Bin:_____ **Rx PCN:**_____ **Mother's 1st Name:** _____

☐ **I certify that I have no insurance coverage. Provide SSN:**_____
(REQUIRED for uninsured - Please see staff if you do not have a SSN)

The following questions will help determine your eligibility to be vaccinated today.	YES	NO
1. Are you feeling sick today or have you tested positive for COVID-19? **If yes, please explain:**		
2. Do you have allergies to medications, food, latex, or vaccines? **If so, please list:**		
3. Have you ever had a serious reaction to any vaccine or other injectable medication in the past? **If yes, please explain:**		
4. Have you received any vaccinations in the past 14 days? **If so, please list:**		
5. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? **If yes, please explain:**		
6. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? **If so, please list with date:**		
7. Do you have a bleeding disorder or are you taking a blood thinner?		
8. **For women:** Are you pregnant or breast feeding?		

Vaccine Administration Info (For Clinic Use Only)

Vaccine	MFR	Lot#	Exp Date	Site	Dose	VIS Date	Admin By:	Date
COVID-19 Vaccine				RA / LA	0.5mL 1st / 2nd	12/20		

☐ Submitted to ImmTrac (Date:_____) ☐Set to Send With Batch Submission

I certify that I am the patient and at least 18 years of age, or the legal guardian of the patient. I certify that the above information is true and correct. Further, I give my consent to the healthcare provider of Family Pharmacy to administer the vaccine I have requested above. I have been given a Vaccine Information Statement or EUA Fact Sheet for the vaccine that I will receive today. I understand the benefits and risks of receiving the above vaccine, and I have been given the opportunity to ask any questions that I may have. I authorize the release of any medical or other information necessary for determining payment benefits under my insurance carrier or HRSA to Family Pharmacy. I hereby release Family Pharmacy and all officers, directors, and employees from any and all liability arising from or in any way related to the administration of the vaccine listed above. ***I understand that I should remain in the vaccine administration area for 15 minutes after receiving the vaccination to be monitored for any potential adverse reactions.***

Signature: _____ **Date:**_____