COVID-19 Vaccine Consent Form

Patient Information (Vaccine Recipient)

Name (Last)	(First)	**DOB**	**Gender**
Address			**Address 2**
City	**State**	**Zip**	**Phone**
Race		**Ethnicity**	
Primary Care Provider Name:			**Mother's Maiden Name:**
Emergency Contact Name:	**Emergency Contact Relation:**		**Emergency Contact Phone:**

Circle the dose receiving: 1st Dose | 2nd Dose | Additional Dose | Updated/Bivalent Booster Dose

If applicable, which vaccine product did you receive last (circle one): Pfizer | Moderna | Janssen | Novavax

Number of COVID-19 Vaccine Doses Received: _____

Date of last COVID-19 Vaccine: _____

Screening Questions

Question	YES	NO	Don't Know
Are you feeling sick today?			
Have you ever had an allergic reaction to a component of the COVID-19 vaccine, including polyethylene glycol (PEG) or polysorbate or a previous dose of COVID-19 vaccine?			
Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			
Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food,pet, venom, environmental, or oral medication allergies.			
Is the person to be vaccinated have a health condition or undergoing treatment that makes them moderately or severely immunocompromised? *This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.*			
Have you previously received a COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?			
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? If yes, when did you receive antibody therapy:			
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
Do you have a bleeding disorder or are you taking a blood thinner?			
Do you have dermal fillers?			
Do you have a history of myocarditis or pericarditis?			
Have you been diagnosed with Multisystem Inflammatory Syndrome?			
Do you have a history of heparin-induced thrombocytopenia (HIT) or thrombosis with thrombocytopenia syndrome (TTS)			
Do you have a history of Guillain-Barre Syndrome (GBS)?			
Have you had COVID-19 in the past 3 months?			

Consent (check each box below after reading and signing)

- ☐ I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet, a copy of which I was provided with this Consent Form. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent Form.
- ☐ I understand that at this time, some COVID-19 vaccines require 2 doses given 21-28 days apart dependent on the manufacturer. If this is my first dose of the COVID-19 vaccine and a second dose is required (Pfizer, Moderna, or Novavax), I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the series.
- ☐ I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur.
- ☐ I understand that I will be receiving the vaccination at no cost to me.

Select One of the Following:

- ☐ If INSURED, check this box attesting to bringing in your **prescription and medical insurance cards**. By selecting, you are also authorizing the pharmacy to bill your insurance on your behalf– understanding you will not incur any costs.
- ☐ If UNINSURED, you must check this box to attest that the following information is true and accurate: I do not have any insurance, including but not limited to, Medicare, Medicaid, or any other private or government-funded benefit plan.

For uninsured patients, please select one of the following that you will present at the pharmacy. *This is needed, but not required, to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program.*

- ☐ Social Security Number
- ☐ State identification number & state of issuance
- ☐ Driver's license number & state of issuance

Pharmacy Use for Insurance Information

Signature of Person to Receive Vaccine & EUA /VIS (or Signature of Parent/Guardian if Patient is < 18 years old)

Signature:_____ **Date:** _____

*****PHARMACY USE ONLY*****

Vaccine	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	☐ 1st	☐ IM - L Arm ☐ IM - R Arm		☐ Moderna ☐ Pfizer ☐ Janssen ☐ Novavax			
COVID-19	☐ 2nd	☐ IM - L Arm ☐ IM - R Arm		☐ Moderna ☐ Pfizer ☐ Novavax			
COVID-19	☐ Additional ☐ Bivalent Booster	☐ IM - L Arm ☐ IM - R Arm		☐ Moderna ☐ Pfizer			

Reason for additional or booster dose (*if applicable*): _____

Pharmacist Name who reviewed this form:_____ **Pharmacist Signature**: _____

If certified vaccinator is different than the pharmacist who reviewed the form:

Name: _____ **Signature**: _____