Vaccine Intake Consent Form

COVID-19 Vaccine	Additional Vaccine(s) Requested	
Comirnaty (Pfizer) **Age 12+** ☐	Influenza ☐	RSV ☐
	Shingles ☐	Pneumonia ☐
	Other _____	

Patient Information

Last Name First Name

Date of Birth Gender Phone Number Email Address

Address City State Zip SSN

Primary Care Provider Name (PCP) PCP Phone # PCP Fax #

PCP Address City State Zip

Prescription Insurance

Pharmacy Insurance Provider ID# Group BIN PCN

Medicare:

☐ Yes ☐No

Is the patient age 65 or older or is the patient Medicare Eligible? Medicare Part B Number (red, white, and blue card)

Screening Questions		Yes	No	Don't Know
1.	In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?	☐	☐	☐
2.	In the past two weeks, have you had contact with anyone who tested positive for COVID-19?	☐	☐	☐
3.	Do you currently or have you in the past 14 days tested positive for COVID-19, had a fever, cough, shortness of breath, or loss of sense of taste and smell	☐	☐	☐
4.	Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	☐	☐	☐
5.	Do you have a history of thrombosis with thrombocytopenia syndrome (TTS) following vaccination with Janssen COVID-19 vaccine, a history of heparin-induced thrombocytopenia (HIT), a bleeding disorder, or are you taking a blood thinner?	☐	☐	☐
6.	In the past 90 days, have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MISA) after a COVID-19 infection?	☐	☐	☐

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Screening Questions (continued)		Yes	No	Don't Know
7.	Do you have any chronic health condition such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, obesity, sickle cell disease, diabetes, heart disease? If Yes, Please List _____	☐	☐	☐
8.	Do you have a history of myocarditis or pericarditis?	☐	☐	☐
9.	Do you have a history of allergic reaction or allergies to latex, medications, food or vaccines (examples: polyethylene glycol, polysorbate, eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If Yes, Please List _____	☐	☐	☐
10.	For women, are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
11.	Have you received any vaccinations or TB skin test in the past 4 weeks?	☐	☐	☐

CONSENT FOR SERVICES: I attest that I am eligible to receive either a 1st, 2nd, or 3rd dose as per current CDC/FDA guidelines. I have been provided with the Vaccine Information Sheet(s) corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request. AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize Mainline Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf. DISCLOSURE OF RECORDS: I understand that Mainline Pharmacy may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated my Primary Care Physician (if I have one}, my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that Mainline Pharmacy will use and disclose my health information as set forth in the Mainline Pharmacy Notice of Privacy Practices (copy is available in-store). Vaccine Clinics: If I am receiving a vaccine through a vaccine clinic, I understand that my name, vaccine appointment date and time will be provided to the clinic coordinator.

X _____

Signature of patient to receive vaccine or person authorized to make the request Date

Vaccine Administration Information for immunizer/Pharmacist use only

Vaccine	Sticker (or…)				Site	Date of VIS	Signature of administrator of vaccine
	Manuf.	Lot	Exp	Dose			
Spikevax '23-'24 12yo+					LD RD	9/11/2023	
Influenza TIV					LD RD	8/6/2021	
Influenza Adjuvanted					LD RD	8/6/2021	
Influenza High Dose					LD RD	8/6/2021	
Shingrix					LD RD	2/4/2022	
PCV					LD RD	5/12/2023	
Abryvso					LD RD	7/24/2023	
Arexvy					LD RD	7/24/2023	