

# COVID Vaccine Intake Consent Form



## Manufacturer/Dose #

Pfizer			Moderna		
Age 12+ Pfizer1 <sup>st</sup> <input type="checkbox"/>	Age 5-11 Pfizer1 <sup>st</sup> <input type="checkbox"/>	Age 3-4 Pfizer1 <sup>st</sup> <input type="checkbox"/>	Age 18+Moderna1 <sup>st</sup> <input type="checkbox"/>	Age 6-17 Moderna 1 <sup>st</sup> <input type="checkbox"/>	Age 3-5 Moderna 1 <sup>st</sup> <input type="checkbox"/>
Age 12+ Pfizer2 <sup>nd</sup> <input type="checkbox"/>	Age 5-11 Pfizer2 <sup>nd</sup> <input type="checkbox"/>	Age 3-4 Pfizer2 <sup>nd</sup> <input type="checkbox"/>	Age 18+Moderna2 <sup>nd</sup> <input type="checkbox"/>	Age 6-17 Moderna 2 <sup>nd</sup> <input type="checkbox"/>	Age 3-5 Moderna 2 <sup>nd</sup> <input type="checkbox"/>
Age 12+ *New* Pfizer Bivalent Booster <input type="checkbox"/>	Age 5-11 Pfizer3 <sup>rd</sup> <input type="checkbox"/>	Age 3-4 Pfizer3 <sup>rd</sup> <input type="checkbox"/>	Age 18+ *New* Moderna Bivalent Booster <input type="checkbox"/>	Age 6-17 Moderna 3 <sup>rd</sup> <input type="checkbox"/>	Age 3-5 Moderna 3 <sup>rd</sup> <input type="checkbox"/>
	Age 5-11 Pfizer ____	Age 3-4 Pfizer4 <sup>th</sup> <input type="checkbox"/>		Age 6-17 Moderna ____	Age 3-5 Moderna ____
	Age 5-11 Pfizer ____	Age 3-4 Pfizer ____		Age 6-17 Moderna ____	Age 3-5 Moderna ____

## 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
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## 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)

COVID-19 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	In the past two weeks, have you had contact with anyone who tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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COVID-19 Screening Questions (continued)		Yes	No	Don't Know
4.	Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	In the past 90 days, have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MISA) after a COVID-19 infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Do you have a history of myocarditis or pericarditis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	For women, are you pregnant or is there a chance you could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Have you received any vaccinations or TB skin test in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Administration Date	Vaccine	VIS Date	Manufacturer
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Lot#	Exp. Date	Route	Site	Volume (ml)
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Administering Immunizer Name & Title

Administering Immunizer Signature