**COVID-19 Vaccine Consent Form **

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** (Last) | **Date of Birth** | **Gender** | **Race** | **Ethnicity** |
| **Name** (First) | **Name** (Middle):  | **Mother’s Maiden Name:**  |
| **Address** |
| **City** | **State** | **Zip** | **Phone Number** |
| **Primary Care Provider Name:**  |
| **Emergency Contact Name: Relation: Phone Number:**  |

**Which COVID-19 Vaccine are your requesting today (Circle One): Moderna or Pfizer**

**Which Dose of the COVID-19 Vaccine are you needing to receive (Circle One): 1st dose /2nd Dose/ 1st Booster/ 2nd Booster**

|  |  |  |  |
| --- | --- | --- | --- |
| **Question** | **YES** | **NO** | **Don’t Know** |
| 1. **Are you feeling sick today?**
 |  |  |  |
| 1. **Have you ever received a dose of COVID-19 Vaccine?**
 |  |  |  |
| * If you have received a dose of COVID-19 Vaccine before:
	+ Vaccine manufacturer for 1st and 2nd dose (ex: Pfizer, Moderna, Johnson & Johnson): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Date of 1st dose: \_\_\_\_\_\_\_\_\_\_\_\_
	+ Date of 2nd Dose \_\_\_\_\_\_\_\_\_\_\_
	+ Date of 1st Booster\_\_\_\_\_\_\_\_\_\_\_Vaccine Manufacturer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Date of 2nd Booster\_\_\_\_\_\_\_\_\_\_
 |
| 1. **Have you ever had an allergic reaction to:**

(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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) |
| * **A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures**
 |  |  |  |
| * **Polysorbate**
 |  |  |  |
| * **A previous dose of COVID-19 Vaccine**
 |  |  |  |
| 1. **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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) |  |  |  |
| 1. **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, environmental, or oral medication allergies.
 |  |  |  |
| 1. **Have you received any vaccine in the last 14 days?**
 |  |  |  |
| 1. **Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?**
 |  |  |  |
| 1. **Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?** *[note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]*
 |  |  |  |
| 1. **Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?**
 |  |  |  |
| 1. **Do you have a bleeding disorder or are you taking a blood thinner?**
 |  |  |  |
| 1. **Are you pregnant or breastfeeding?**
 |  |  |  |

**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 (Click [here](https://www.fda.gov/media/144414/download) for the Pfizer 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, the COVID-19 vaccine requires 2 doses given 21-28 days apart depending on the manufacturer. If this is my second dose, I will bring my vaccine card with me to be completed.
* I understand that if I am receiving a Booster Dose of the Vaccine: If 1st Booster it has been at least 6 months from the date of my Second Dose of either Moderna/Pfizer and at least 2 months from last dose of Johnson and Johnson. If this is my second booster it has been at least 4 months from the 1st booster.
* 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.
* If insured, **please bring in your prescription and medical insurance cards** for your vaccine appointment. I authorize the pharmacy to bill my insurance on my behalf for the immunization – understanding I will not incur any costs.

 If uninsured, you must check the box below 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.

 If uninsured patients, I am unable to provide you vaccine for you today and suggest making an appointment at the local health dept.

 **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 Dose
* 2nd Dose
* 3rd Dose
 | * IM - L Arm
* IM - R Arm
 |   | * Moderna
* Pfizer
 |  |  |  |
| COVID-19 | * 1st Dose
* 2nd Dose
* 3rd Dose
 | * IM - L Arm
* IM - R Arm
 |   | * Moderna
* Pfizer
 |  |  |  |

 **Pharmacist** **Name** who reviewed this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Pharmacist** **Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 **Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_