INFORMED CONSENT FOR COVID-19 IMMUNIZATION

Name: _____ **Birthday:** _____**Phone:** _____

Street Address: _____**City:** _____ **State**_____ **Zip:** _____

Email : _____ **COUNTY :** _____ **Sex: M F**

Race: Asian American Indian/Alaskan Native Black/ African American **Ethnicity:** Hispanic or Latino
Pacific Islander White/ Caucasian Other: _____ Non-Hispanic or Latino

PLEASE ATTACH COPY OF INSURANCE CARD & DRIVER LICENSE Decline to State.

Please read the questions below. Indicate Yes or No for the person receiving a vaccine today.

1. Has this person ever had a severe reaction to any vaccine, which required medical care?	YES	NO
2. Is this person allergic to eggs, baker's yeast, streptomycin, or neomycin?	YES	NO
3. Does this person have a fever, diarrhea or vomiting today?	YES	NO
4. Is this person or anyone in the home being treated with biological medications, steroids, chemotherapy, radiation for cancer, have HIV/AIDS, or any immune deficiency disease?	YES	NO
5. Does this person have a seizure disorder, brain disorder, history of Guillain-Barre Syndrome, or nervous system disorder?	YES	NO
6. Does this person have any long-term health conditions? (ex. Heart disease, diabetes, asthma, COPD, kidney disease, etc.)	YES	NO
7. Has this person had immune globulin or blood transfusion in the past year?	YES	NO
8. Has this person received any vaccinations in the past four weeks?	YES	NO
9. Is this person pregnant, or planning pregnancy in the next three months?	YES	NO

Please **CIRCLE** all of the following conditions that apply to the person receiving a vaccine.

Diabetes Immunocompromised **2nd dose since 6 months** AGE 5-11 **Age 12-18 years** Age over 65

I have read, or have had read to me, the information regarding the vaccine/vaccines listed above. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine/vaccines. I consent to, or give consent for, the administration of the vaccine/vaccines marked above to:

_____ _____ _____

Patient/Guardian Name (print) Signature of Patient or Parent/Guardian if age 5-18 years Date

Immunizations given will be reported to local or state immunization registries as required unless otherwise requested.

This Section to be Completed by Pharmacist and/or Administrator.

Date	Vaccine	Manufacturer	Lot #	Expiration	Dose	Site	Series
	COVID-19	**MODERA PFIZER J & J**			0.5 ML 0.3 ML 0.25 ML 0.2 ML	**LEFT / RIGHT** DELTOID	**1ST /2ND OR 3RD (BOOSTER)**

Name of administrator of vaccine: _____ Signature: _____ Date: _____

Pharmacy Name _____ **Address**_____

PRESCRIPTION FOR COVID-19 IMMUNIZATION

Date _____

Patient Name: _____ DOB_____

I am here for my 1st Dose / 2nd Dose / Booster Dose

Covid-19 **Moderna / Johnson & Johnson** Vaccine # 0.5ml *** **Pfizer** Vaccine # 0.3 ML //

BOOSTER MODERNA 0.25ML / J & J 0.5 ML **PFIZER** BOOSTER 0.3 ML

Kids 5-11 age 0.2 ml (PFIZER) // KIDS 12-18 YEARS 0.3 ML (PFIZER)

Inject IM as per protocol

INSURANCE INFORMATION FOR PERSON RECEIVING COVID-19 VACCINE
(IF YOU ARE ATTACHING COPY OF INSURANCE CARD THEN DONOT FILL OUT INSURANCE INFO)

ID # _____

RX GROUP # _____

BIN # _____

PCN# _____

For COVID Vaccine billing purposes only, a driver's license or state identification number to verify eligibility when Third Party Processing cannot be completed. (OPTIONAL IF YOU GIVE COPY OF DRIVER LICENSE)

Driver's License Number		State	

Patient or Guardian Name		Signature		Date	

****If you are age 65 and older the following information needs to be filled out.****

I hereby consent to the release of medical information when necessary for billing, reimbursements and eligibility verification for COVID-19 Vaccine purposes only.

_____
Name of Beneficiary

_____
Beneficiary Signature

_____
Medicare ID Number or Last 4 of your Social Security Number