

COVID-19 VACCINE INFORMED CONSENT FORM



Rev. 06/17/22

PATIENT INFORMATION

Full Name (First MI Last): _____ Date of Birth: _____ Age: _____

Email: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Gender: Male Female Race: _____ Ethnicity: _____

Primary Care Doctor: _____ City/State: _____

How many doses of vaccine have you received? 0 1 2 3 4 Other _____ Date of last dose: _____

If 1+ doses, which vaccine did you get for your last dose? Pfizer (12+) Pfizer Pediatric (5-11) Pfizer Young Pediatric (6mo-4yr)
 Moderna (12+) Moderna Pediatric (6-11) Moderna Young Pediatric (6mo-5yr) Janssen (18+) Other

If this is your first dose, which vaccine would you prefer to receive? Pfizer Moderna Janssen

If you received Janssen and are getting a booster dose, which vaccine would you prefer to receive? Pfizer Moderna

Are you immunocompromised? Please mark any of the following conditions that you have:

- I have been receiving active cancer treatment for tumors or cancers of the blood
- I have received an organ transplant and am taking medicine to suppress the immune system
- I have received a stem cell transplant within the last 2 years or am taking medicine to suppress the immune system
- I have moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
- I have advanced or untreated HIV infection
- I have active treatment with high-dose corticosteroids or other drugs that may suppress my immune response
- None of the above

For Those who **ARE** Immunocompromised and Received Pfizer or Moderna

If you have received two doses total of Pfizer or Moderna COVID-19 vaccine, a third dose is recommended at least 28 days after the date of your last dose. You should receive the vaccine from the same manufacturer as you received for your first two doses.

If you have received three doses of Pfizer COVID-19 vaccine AND are 5 to 17 years, a booster dose of Pfizer is recommended at least 3 months after the date of your last dose.

If you have received three doses of COVID-19 vaccine AND are 18 years or older, a booster dose is recommended at least 3 months after the date of your last dose.

Which booster vaccine would you prefer to receive? Pfizer (12+) Moderna (18+)

If you have received your booster dose of COVID-19 vaccine AND are 12 years or older, a second booster dose is recommended at least 4 months after the date of your last dose.

Which booster vaccine would you prefer to receive? Pfizer (12+) Moderna (18+)

For Those who are **NOT** Immunocompromised and Received Pfizer (5+) or Moderna (18+)

If you have received two doses total of COVID-19 vaccine, a booster dose is recommended at least 5 months after the date of your last dose.

Which booster vaccine would you prefer to receive? Pfizer (12+) Pfizer Pediatric (5-11) Moderna (18+)

If you have received your booster dose of COVID-19 vaccine AND are 50 years or older, a second booster dose is recommended at least 4 months after the date of your last dose.

Which booster vaccine would you prefer to receive? Pfizer (12+) Moderna (18+)

Are you planning to get another vaccine at this time? Yes No

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SCREENING QUESTIONS: Please select the correct option below.

	YES	NO	Don't Know or N/A
Do you feel sick today?			
Have you had COVID-19 within the last three months?			
Do you have a history of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)?			
Do you have a history of thrombosis with thrombocytopenia syndrome (TTS)?			
Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?			
Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?			
Do you have an allergy to any food, medication or vaccine? If so, please specify allergy: _____			
Have you ever had a serious reaction or fainted after receiving any vaccination?			
Do you carry an EpiPen?			
Do you have a bleeding disorder or take a blood thinner?			
Have you ever had a seizure, brain disorder, or Guillain-Barre Syndrome?			
Do you have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies?			
Do you have a history of myocarditis or pericarditis?			
Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?			
FOR WOMEN: Are you currently pregnant or breastfeeding?			

INSURANCE INFORMATION

- I hereby authorize the pharmacy to bill my insurance on my behalf for the COVID-19 vaccine administration fee & receive payment.
 Insurer: _____ Member #: _____
 Rx Group: _____ BIN #: _____ PCN #: _____
- If you do not have insurance, please provide your Social Security Number or Driver's License: _____

ACKNOWLEDGEMENTS

- I attest that the answers provided here are accurate to the best of my knowledge.
- I understand the benefits and risks of the vaccination(s) as described in the Vaccine Information Sheet (VIS) or Emergency Use Authorization (EUA), a copy of which I was provided with this Consent & Release. 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 & Release.
- I have received a copy of the notice of Privacy Practices. I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the pharmacy & of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Signature of Patient to Receive Vaccine

(or Signature of Power of Attorney or Legal Guardian) _____ Date: _____

Parent/Guardian Name: _____ Relationship to patient: _____

----- PHARMACY USE ONLY -----

VACCINE	BRAND/MFG	DOSAGE	ROUTE	SITE	EUA /VIS	LOT	EXP. DATE	STATUS
COVID-19	<input type="checkbox"/> Moderna (12+)	<input type="checkbox"/> 0.5mL <input type="checkbox"/> 0.25mL	IM	R or L Arm	06/17/22			<input type="checkbox"/> Billed
COVID-19	<input type="checkbox"/> Moderna (6-11)	<input type="checkbox"/> 0.5mL	IM	R or L Arm	06/17/22			<input type="checkbox"/> Iris
COVID-19	<input type="checkbox"/> Moderna (6mo-5yr)	<input type="checkbox"/> 0.25mL	IM	R or L Arm or Thigh	06/17/22			<input type="checkbox"/> Fax PCP
COVID-19	<input type="checkbox"/> Pfizer (12+)	<input type="checkbox"/> 0.3mL	IM	R or L Arm	03/29/22			<input type="checkbox"/> Scanned
COVID-19	<input type="checkbox"/> Pfizer (5-11)	<input type="checkbox"/> 0.2mL	IM	R or L Arm	05/17/22			
COVID-19	<input type="checkbox"/> Pfizer (6mo-4yr)	<input type="checkbox"/> 0.2mL	IM	R or L Arm or Thigh	06/17/22			
COVID-19	<input type="checkbox"/> J&J	0.5mL	IM	R or L Arm	05/05/22			

Signature of Pharmacist who administered _____ Date Administered: _____