COVID-19 VACCINE IMMUNIZATION CONSENT FORM

Name: _____ **Phone:** _____

Date of Birth: _____ **Age:** _____ **Gender (circle): male / female**

Race: ☐White ☐Hispanic/Latino ☐Black/African American ☐Native American /Alaska Native

☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐Other

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Card holder Name: _____ **Company**: _____ **Rx BIN**: _____

Member ID: _____ **PCN:**_____ **Rx Group:** _____ **Medicare ID:** _____

MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. If you answer "YES" you may not be able to receive the COVID-19 vaccine.	**YES**	**NO**
Have you had a previous COVID-19 vaccine? If yes, date?		
Have you had any vaccines within the previous 14 days?		
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?		
Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component or injectable therapy? Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness.		
Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive COVID-19 vaccine, a discussion with your healthcare provider can help make informed decision.		
Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe obesity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive COVID-19 vaccine unless otherwise contraindicated.		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Vaccination should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced immune responses.		
• **NOTE:** Depending on vaccine type, a second dose of COVID-19 vaccine **is** due. **(21 days for Pfizer-BioNTech/28 days for Moderna)**. **Janssen** vaccine is a single dose vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date.		

Consent and waiver: I consent to the staff to administer the medication(s) mentioned below. I have read or had explained to me the **Vaccine Recipient Emergency Use Authorization** (EUA) **Fact Sheet** for COVID-19 vaccine risks and benefits and understand the benefits and risks of receiving this medication and choose to assume this risk. I fully release and discharge the pharmacy, its affiliations and their officers, and employees from any illness, injury, loss, or damage that may result there from. I acknowledge that ***I have received a copy of the pharmacy's privacy policies according to HIPPA***. I assign payment of authorized insurance benefits due to me to be paid to the pharmacy and will pay any copay or deductible that result. I consent the release of medical information when necessary for billing, reimbursement, and medical protocol. I also allow for the pharmacy to report any medications received to Arkansas Immunization Information System. I am aware that an immunization certified student pharmacist might be administering this medication. **I agree to wait near the vaccination area for a minimum of 15 minutes, or 30 minutes if history of adverse reaction to vaccines, to receive treatment in case of adverse reaction.**

Signature of patient/guardian: _____ **Date:** _____

STAFF USE ONLY: COVID-19 VACCINE ADMINISTRATION		☐ Pfizer-BioNTech	☐ Moderna	☐ Janssen
Route	**Site Code**	**Dosage mL**	**MFG Code**	**Lot Number**

Signature and Title of Administrator: _____ **Date:**_____