Medley Pharmacy, Inc COVID-19 Vaccine Form

Patient's Full Name: _____

Date of Birth: _____ **Age:** _____

Address, City, State, Zip:_____

_____

Phone Number: _____

Email: _____

Gender: Male____ Female _____

Race:

____ African American ____ American Indian
____ Asian ____ Caucasian
____ Native Hawaiian/Other Pacific Islander
____ Prefer not to answer/Unknown

Ethnicity:

____ Hispanic ____ Non Hispanic/Latino
____ Unknown ____ Prefer not to answer

For Clinic Use:

Date:

Time:

Administration Site:

R-Deltoid L-Deltoid Other: _____

EUA/Patient Fact Sheet: Pfizer 2/25/21; JJ 2/27/21; Moderna 12/2020

Administered By:_____

Supervising Pharmacist:_____

Pharmacist acknowledges verification of patient screening questions, patient counselling, and EUA/Fact sheet provided.

End of Observation:_____
Card Provided:_____

Patient Consent:

I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA), a copy of which I was provided with this Consent and 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 and 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 and 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.

Billing:

_____ I have insurance. (Please provide a copy of your insurance card. For Medicare recipients, please provide a copy of your red, white and blue card even if you are on a Medicare Advantage Plan.)

_____ I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government-funded health benefit plan.

In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for uninsured patients, please provide:

Social Security Number: _____

I authorize the pharmacy to bill my insurance on my behalf for the immunization administration.

For minors under 18: (A parent or guardian must sign the consent form)

_____ I agree to allow treatment with diphenhydramine (Benadryl), epinephrine, and/or calling the ambulance in the event of an adverse reaction or anaphylaxis.

Signature of consent for the above:

_____ Date: _____

Relationship (if under 18): _____

Please attach a copy of your **prescription** insurance card to this form.

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name _____

Age _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.
If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked.
If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Another product _____			
3. 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	☐	☐	☐
4. 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.)	☐	☐	☐
5. 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.	☐	☐	☐
6. Have you received any vaccine in the last 14 days?	☐	☐	☐
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
10. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
11. Are you pregnant or breastfeeding?	☐	☐	☐