Medley Pharmacy, Inc COVID-19 Vaccine Form

Revised 1/9/2022

Dose: 1st 2nd 3rd

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:***
Rx: ***Time:***

Administer Intramuscularly per Standing Order*

- o Moderna
  - o 0.25 ml
  - o 0.5 ml
- o Pfizer (12 +) 0.3ml
- o Pfizer (5-11 yo) 0.2 ml
- o Janssen 0.5ml

Lot:

Exp:

Administration Site:

R-Deltoid L-Deltoid Other: _____

EUA/Patient Fact Sheet: Pfizer 01/03/22; JJ 12/14/21; Moderna 01/07/22

Administered By:_____

Supervising Pharmacist:_____
Pharmacist acknowledges verification of patient screening questions, patient counseling, and EUA/Fact sheet provided.

*Standing order issued by Dr. George Turabelidze

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.

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

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.

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 Vaccination

For vaccine recipients:

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.

Name _____

Age _____

	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(s) did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• How many doses of COVID-19 vaccine have you received? _____			
• Did you bring your vaccination record card or other documentation?	☐	☐	
3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)*	☐	☐	☐
4. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	☐	☐	☐
5. 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 caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including either of the following:			
○ Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
6. 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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

7. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ Have a history of Guillain-Barré Syndrome (GBS)

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists