



Family Pharmacy Clinical Services

COVID-19 Vaccination Consent Form

Which Brand? MODERNA PFIZER JANSSEN (J&J)
Which Dose? 1ST DOSE 2ND DOSE 3RD DOSE BOOSTER
History of COVID Vaccine: Brand: _____ Date of 1st Dose: _____ Date of 2nd Dose: _____

Patient Name: _____ **Date of Birth:** ____/____/____
First MI Last MM/DD/YYYY

Sex: M F **Race/Ethnicity:** _____ **Phone:** (____) _____

Address: _____
Street or P.O. Box City State Zip

Medicare ID: _____ **Mother's 1st Name:** _____

Private Ins: Rx Bin: _____ **Rx PCN:** _____ **Rx ID#:** _____ **Rx Grp#:** _____

I certify that I have no insurance coverage. Provide SSN: _____

<i>The following questions will help determine your eligibility to be vaccinated today.</i>	YES	NO
1. Are you feeling sick today or have you recently tested positive for COVID-19? If yes, please explain:		
2. Do you have allergies to medications, food, latex, or vaccines? If so, please list:		
3. Have you ever had a serious reaction to any vaccine or other injectable medication in the past? If yes, please explain:		
4. Do you have any other chronic health conditions that increase your risk for COVID or does your job increase your risk? If so, please list:		
5. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies (required for 3rd dose)?		
6. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? If so, please list with date:		
7. Do you have a bleeding disorder or are you taking a blood thinner?		
8. For women: Are you pregnant or breast feeding?		

Vaccine Administration Info (For Clinic Use Only)

Vaccine	MFR	Lot#	Exp Date	Site	Dose	VIS Date	Admin By:	Date
COVID-19 Vaccine				RA / LA				

Submitted to ImmTrac (Date: _____) Set to Send With Batch Submission

*I certify that I am the patient and at least 18 years of age, or the legal guardian of the patient. I certify that the above information is true and correct. Further, I give my consent to the healthcare provider of Family Pharmacy to administer the vaccine I have requested above. I have been given a Vaccine Information Statement or EUA Fact Sheet for the vaccine that I will receive today. I understand the benefits and risks of receiving the above vaccine, and I have been given the opportunity to ask any questions that I may have. I authorize the release of any medical or other information necessary for determining payment benefits under my insurance carrier or HRSA to Family Pharmacy. I hereby release Family Pharmacy and all officers, directors, and employees from any and all liability arising from or in any way related to the administration of the vaccine listed above. **I understand that I should remain in the vaccine administration area for 15 minutes after receiving the vaccination to be monitored for any potential adverse reactions.***

Signature: _____ **Date:** _____