Immunization Documentation and Consent Form-- For COVID-19 Vaccine

Full Name

Phone Number | *Date of Birth (mm/dd/yyyy)* | *Age* | *M F* *Gender*

Home Address | *City* | *State* | *Zip Code*

___ American Indian or Alaska Native; ___ Native Hawaiian or Pacific Islander; ___Asian; ___ Black/African American; ___ White; ___Hispanic/Latino; ___Other

Please, answer the following questions	Yes	No	???
1. Do you have a fever or illness today?	___	___	___
2. Have you or a household contact been diagnosed with COVID-19 in the past 14 days?	___	___	___
3. Do you have allergies to medications, food (e.g. eggs), latex, or a vaccine component (e.g. polyethylene glycol / PEG)?. If yes, please list the allergies:	___	___	___
4. Have you ever had a severe / anaphylactic reaction to any substance?	___	___	___
5. Have you ever felt dizzy or passed out after a vaccination?	___	___	___
6. Do you have a chronic condition or long-term health problem**? If yes, please check all that apply.** ___Anemia ___Asthma ___Diabetes ___Heart disease ___Kidney disease ___Liver disease ___Lung disease ___Obesity ____Smoker	___	___	___
7. For the past 3 months, have you taken medications that affect your immune system, such as prednisone or other steroids, anti-cancer drugs, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis; or have you had radiation treatments?	___	___	___
8. Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder?	___	___	___
9. Have you previously received a dose of ANY COVID vaccine? If yes, list manufacture:	___	___	___
10. **For women**: Are you pregnant or considering becoming pregnant in the next month?	___	___	___

I certify I am the patient and at least 18 years of age; the legal guardian of the patient; or a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. I have read, or have had read to me, the EUA / vaccine information statement information for the COVID vaccine I am receiving and have been offered a copy of the notice of privacy practices. I have been able to ask questions about the vaccine, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine. I consent to the administration of the vaccine requested. I understand that the vaccination information will be shared with the state immunization database. **I agree to stay in the general area for 15-30 minutes** after receiving my vaccination in case any immediate reactions occur. If I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); the subsidiaries and affiliates of the pharmacy; the respective directors, officers, employees, and agents of the pharmacy and its subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability that might arise from this vaccination.

_____ _____

Patient (Parent or legal guardian) signature | Date

BELOW SECTION FOR PHARMACIST USE ONLY:

COVID-19 Vaccine Prescribing Info:

_____Moderna COVID-19 Vaccine (primary dose)--Dose #_____
Inject 1 dose (0.5 ml) IM today
#0.5 ml 0 Refills
Date Written is date of consent form
Prescribing Pharmacist: see vaccinator signature

_____Moderna COVID-19 Vaccine (booster dose)--Dose #_____
Inject 1 dose (0.25 ml) IM today
#0.25 ml 0 Refills
Date Written is date of consent form
Prescribing Pharmacist: see vaccinator signature

_____Janssen COVID-10 Vaccine (primary or booster dose)--Dose #_____
Inject 1 dose (0.5 ml) im today
#0.5 ml 0 Refills
Date Written is date of consent form
Prescribing Pharmacist: see vaccinator signature

Exp Date:
NDC#:
VIS Date:

Manufacturer:
Lot:

Admin Site: Left Arm_____ Right Arm _____

Vaccinator (print):_____

Vaccinator (sign):_____
Date Administered:_____

By signing as administrator you are confirming that contraindications and side effects have been reviewed and a current VIS was provided to the patient receiving the vaccine.