

COVID Vaccine Intake Consent Form



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* INDICATES REQUIRED FIELDS

Patient Information

* Last Name	* First Name	* Date of Birth	Gender
* Address	* City	* State	* Zip
* Phone Number	Primary Care Provider (PCP) Name	PCP Phone Number	
* Allergies			

Are you a **resident** of a Long Term Care facility or an **employee/staff member** ?

Is this the patient's **first** or **second** dose of the COVID-19 vaccination?

Insurance Information: (For onsite clinics, please ensure a copy of the patient's insurance card(s) was collected)

Prescription Insurance: Yes No
*Are you the primary cardholder? *If no, include the primary cardholder's DOB

* Prescription Benefit Plan Name	* Cardholder ID #	* RX Group ID	* BIN	* PCN
Medicare Fields: <input type="radio"/> Yes <input type="radio"/> No				

*Is the Patient age 65 or older or Medicare Eligible? *Medicare Part A/B ID Number (MBI) **Note:** MBI is required for all patients age 65 and older, or Medicare eligible. Refer to your Medicare Red, White, and Blue card

Medical Insurance: Yes No
*Medical Insurance Provider *Cardholder ID # *Group ID *Payer ID
*Is the patient the primary cardholder? *If no, include primary cardholder's DOB

***If uninsured, you must check the box below to attest that the following information is true and accurate:**

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 either (a) a valid Social Security number, (b) state identification number and state of issuance, OR (c) a driver's license number and the state of issuance.

*Social Security Number or State Identification Number & State or Driver's License Number & State

Potential Contraindications

	YES	NO	DON'T KNOW
1. Are you feeling sick today?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Have you ever received a dose of COVID-19 vaccine? If yes , which vaccine product? <input type="radio"/> Pfizer <input type="radio"/> Moderna <input type="radio"/> Another product: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) in the past? <i>Example: a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was the severe allergic reaction after receiving a COVID-19 vaccine?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was the severe allergic reaction after receiving another vaccine or injectable medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was the severe allergic reaction related to receiving Polyethylene Glycol?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Have you received any vaccines in the past 14 days?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Last Name

First Name

Date of Birth

Potential Considerations

	YES	NO	DON'T KNOW
1. Do you have a bleeding disorder or are you taking a blood thinner?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Do you have a weakened immune system or currently take medications that can diminish your immune response (i.e., HIV medications, steroids, anticancer drugs, or radiation treatment, etc.?)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. For women, are you currently pregnant or breastfeeding?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet(s) or patient fact sheet corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize Gateway Medical Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid, or the HRSA

COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS: I understand that Gateway Medical Pharmacy may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at Gateway Medical Pharmacy (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that Gateway Medical Pharmacy will use and disclose my health information as set forth in the Notice of Privacy Practices (copy is available by requesting a paper copy from the pharmacy).

X**Signature of patient to receive vaccine (or parent, guardian, or authorized representative)**

Date

If signing on behalf of the patient, you are stating that you are authorized to provide the required consents on behalf of the patient.

Name of parent, guardian, or authorized representative

Phone Number

Relationship

Vaccine Administration Information for Immunizer/Pharmacist use only

Administration Date	Vaccine	VIS Date	Manufacturer	Volume (mL)
			<input type="radio"/> L <input type="radio"/> R	
Lot #	Exp. Date	Route	Site	Notes
Administering Immunizer Name & Title			Administering Immunizer Signature	