

COVID-19 Vaccine Intake Consent Form



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.

NAME: _____
 DATE OF BIRTH: _____
 ADDRESS: _____
 CITY/STATE/ZIP: _____
 PHONE NUMBER: _____

RACE (circle response): American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander
 Black or African American Unknown Other _____

	YES	NO	I DON'T KNOW
1. Have you been diagnosed with, experienced symptoms of, or had close contact with anyone who has tested positive for COVID-19 in the last 14 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever received a dose of COVID-19 vaccine? • If yes, which vaccine product did you receive? Please circle. Pfizer Moderna Janssen (J&J) Other Product	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. 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, 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Check all that apply to you:			
<input type="checkbox"/> Am a female between ages 18 and 49 years old			
<input type="checkbox"/> Am a male between ages 12 and 29 years old			
<input type="checkbox"/> Have a history of myocarditis or pericarditis			
<input type="checkbox"/> Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies			
<input type="checkbox"/> Have a history of heparin-induced thrombocytopenia			
<input type="checkbox"/> Am currently pregnant or breastfeeding			
<input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum			
<input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection			
<input type="checkbox"/> Have a bleeding disorder			
<input type="checkbox"/> Take a blood thinner			
<input type="checkbox"/> Am currently pregnant or breastfeeding			
<input type="checkbox"/> History of Guillain-Barré Syndrome (GBS)			

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)
Lot #	Exp. Date	Route	<input type="radio"/> L <input type="radio"/> R Site	Notes
Administering Immunizer Name & Title			Administering Immunizer Signature	

DATE VIS/EUA WAS GIVEN _____