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, White, 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?	☐	☐	☐
2. Are you feeling sick today?	☐	☐	☐
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			
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	☐	☐	☐
5. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?	☐	☐	☐

6. 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
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Have a history of heparin-induced thrombocytopenia
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Am currently pregnant or breastfeeding
- ☐ 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	Site ○ L ○ R	**Notes**

Administering Immunizer Name & Title	Administering Immunizer Signature

DATE VIS/EUA WAS GIVEN____________________________