Vaccine Intake Consent Form

GATEWAY MEDICAL PHARMACY

For vaccine recipients:
The following questions will help us determine if there is any reason you should not get the 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: _____

Gender (circle response): Male, Female
Ethnicity (circle response): Hispanic or Latino, Non-Hispanic or Latino, Unknown
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 any other vaccinations or skin tests in the past 8 weeks?	☐	☐	☐
4. Have you ever had an allergic reaction to latex, medications, food or vaccines? *(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.)* • Examples (not all inclusive): ○ *Polyethylene glycol (PEG), polysorbate, eggs, gelatin, bovine protien, gentamicin, polymixyn, neomycin, phenol yeast or thimerosal* If yes please list:_____	☐	☐	☐
5. Have you ever had a reaction to any vaccine or an injectable medication, including fainting or dizziness?	☐	☐	☐
6. Have you ever had a seizure disorder, a brain disorder, history of Guillian-Barre syndrome or any other nervous system problem?	☐	☐	☐
7. Do you have any chronic health conditions? If yes please list:_____	☐	☐	☐
8. For women: Are you pregnant or may become pregnant in the next month?	☐	☐	☐
9. Do you have a condition that may weaken your immune system? *Examples: Cancer, leukemia, lymphoma, HIV/AIDS, transplant*	☐	☐	☐
10. Do you currently take any medications that may weaken your immune system *Examples: Humira, Remicade, Enbrel, high dose steroid therapy, methotrexate, azathiprine, antivirals, anticancer drugs or radiation*	☐	☐	☐
11. For COVID-19 Vaccine Only: Have you been treated with antibody therapy for COVID-19? *Examples: monoclonal antiboides or convalescent plasma*	☐	☐	☐
12. Are you currently taking any medication to thin the blood?	☐	☐	☐

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

Admin Date	Vaccine	NDC	VIS Date	Date VIS Given	Lot Number	Expiration Date	Manufacturer

Site/Route	Dose	Immunizer Name (print)	Immunizer Signature

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