# Longley's Pharmacy COVID-19 Vaccine Consent Form

## Patient Information (Vaccine Recipient):

| | | | | |
|---|---|---|---|---|
| **Name** (Last) | (First) | **Date of Birth** | **Age** | **Gender** ☐M ☐F |
| **Address** | | **Race** ☐White ☐Black ☐Asian ☐Pacific Islander ☐Native American ☐Other | **Ethnicity** ☐Hispanic ☐Not Hispanic | |
| **City** | **State** | **Zip** | **Phone Number** | |
| **Primary Care Provider Name:** | | | | |
| **Emergency Contact Name:** | **Relation:** | **Phone Number:** | | |

## Screening Questions:

| Question | YES | NO | Don't Know |
|---|---|---|---|
| **1. Are you feeling sick today?** | ☐ | ☐ | ☐ |
| **2. Have you ever received a dose of COVID-19 Vaccine?**<br>• If yes, which vaccine product(s) did you receive?<br>☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Novavax ☐ Another Product:_____<br>• How many doses of COVID-19 vaccine have you received? _____<br>• Did you bring your vaccination record card or other documentation? | ☐<br><br><br>☐ | ☐<br><br><br>☐ | ☐ |
| **3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised?** (This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome) | ☐ | ☐ | ☐ |
| **4. Have you received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?** | ☐ | ☐ | ☐ |
| **5. 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)<br>• **A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures**<br>• **A previous dose of COVID-19 Vaccine** | ☐<br><br>☐ | ☐<br><br>☐ | ☐<br><br>☐ |
| **6. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?** (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.) | ☐ | ☐ | ☐ |

**7. Check all that apply to you:**

- ☐ **I have a history of myocarditis or pericarditis**
- ☐ **I have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)**
- ☐ **I have a history of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)**
- ☐ **I have a history of thrombosis with thrombocytopenia syndrome (TTS)**
- ☐ **I have a history of Guillain-Barré Syndrome (GBS)**
- ☐ **I have a history of COVID-19 disease within the past 3 months**
- ☐ **I have been vaccinated with the monkeypox vaccine in the last 4 weeks**



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## Consent (check each box below after reading and signing):

- ☐ I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet, a copy of which I was provided with this Consent Form. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent Form.

- ☐ I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur.

- ☐ I understand that I will be receiving the vaccination at no cost to me.

- ☐ If insured, **please bring in your prescription and medical insurance cards** for your vaccine appointment. I authorize the pharmacy to bill my insurance on my behalf for the immunization – understanding I will not incur any costs.

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 benefit plan.

For uninsured patients, please select at least one of the following that you will bring with you to your appointment.

*This is needed in order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program.*

- ☐ Social Security Number
- ☐ State identification number and state of issuance
- ☐ Driver's license number and state of issuance

| Pharmacy Use for Insurance Information | |
|---|---|
| BIN: | PCN: |
| ID: | GRP: |
| SSN: | DL#: |

**Signature of Person to Receive Vaccine & EUA /VIS (or Signature of Parent/Guardian if Patient is < 18 years old)**

**Signature:** _____ **Date:** _____

*****PHARMACY USE ONLY*****

| Vaccine | Dose | Route | Vaccine Manufacturer | Lot Number | Expiration Date | Date Dose Administered | Date on VIS/EUA |
|---|---|---|---|---|---|---|---|
| COVID-19 (bivalent) | ☐ 0.2mL<br>☐ 0.25mL<br>☐ 0.3mL<br>☐ 0.5mL | ☐ IM - L Arm<br>☐ IM - R Arm | ☐ Pfizer<br>☐ Moderna | | | | |

**Pharmacist Name** who reviewed this form: _____ **Pharmacist Signature**: _____

If **certified vaccinator** is different than the pharmacist who reviewed the form:

**Name**: _____ **Signature**: _____

☐ Insurance Eligibility Check Performed ☐ Billing Submitted ☐ Reported to GRITS Notes:_____