# COVID VACCINE CONSENT FORM (1.4)

## FACILITY INFORMATION:

FACILITY NAME | TELEPHONE

ADDRESS | CITY | STATE | ZIP

## PATIENT INFORMATION:

LAST NAME | FIRST NAME | DATE OF BIRTH | GENDER

ADDRESS | CITY | STATE | ZIP

RACE *REQUIRED ☐White ☐Black ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐American Indian/Alaska Native ☐Other ☐Unknown

ETHNICITY *REQUIRED ☐Hispanic or Latino ☐Not Hispanic or Latino

MOTHER'S NAME | MOTHER'S MAIDEN NAME

PRIMARY CARE PROVIDER (PCP) NAME | PCP PHONE NUMBER | PCP FAX NUMBER

PCP ADDRESS | CITY | STATE | ZIP

ARE YOU A RESIDENT OR EMPLOYEE OF THE FACILITY? ☐ RESIDENT ☐ EMPLOYEE

IS THIS THE PATIENT'S FIRST OR SECOND DOSE OF THE COVID-19 VACCINATION? ☐ FIRST DOSE ☐ SECOND DOSE

**INSURANCE INFORMATION:**
*A COPY OF YOUR INSURANCE CARD (FRONT & BACK) IS* ***REQUIRED***:

ARE YOU THE PRIMARY CARDHOLDER? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE THE PRIMARY CARDHOLDER'S NAME BELOW:

INSURANCE CARRIER NAME | INSURANCE/MEDICARE ID #

## IF UNINSURED, YOU MUST CHECK THE BOX BELOW TO ATTEST THAT THE FOLLOWING INFORMATION IS TRUE AND ACCURATE

☐ I attest that I do not have any insurance, including but not limited to Medicaid, Medicare, or any other government-funded or private 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, either (a) a valid Social Security number, **OR** (b) state identification number & state issuance, **OR** (c) a driver's license number & state of issuance must be provided.

(a) SOCIAL SECURITY NUMBER | **OR** (b) STATE IDENTIFICATION NUMBER & STATE | **OR** (c) DRIVER'S LICENSE NUMBER & STATE

## COVID-19 SCREENING QUESTIONS

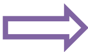
| COVID-19 SCREENING QUESTIONS | YES | NO | I DON'T KNOW |
|---|---|---|---|
| 1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19? | ☐ | ☐ | ☐ |
| 2. In the past two weeks, have you had contact with anyone who tested positive for COVID-19? | ☐ | ☐ | ☐ |
| 3. Have you had the new onset of fever, chills, couch, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea? | ☐ | ☐ | ☐ |

★ Patient Temperature: *(To be filled out by the VACCINATOR)* | Date:

| LAST NAME | DATE OF BIRTH |
|---|---|

| IMMUNIZATION SCREENING QUESTIONS | YES | NO | I DON'T KNOW |
|---|---|---|---|
| 1. Are you sick today? For example: cold, fever, acute illness? | ☐ | ☐ | ☐ |
| 2. Do you any allergies/reactions to any medications, vaccines, food or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.) | ☐ | ☐ | ☐ |
| 3. Have you ever had a serious reaction after receiving a vaccination? Have you ever fainted, particularly with vaccines? Have you ever been cautioned or warned about receiving certain vaccines or receiving vaccines outside of a medical setting by a doctor or other healthcare professional? | ☐ | ☐ | ☐ |
| 4. Do you take anticoagulation medication? For example: Coumadin/warfarin or other blood thinner? | ☐ | ☐ | ☐ |
| 5. Have you had a seizure or a brain or other nervous system problem or Gillian Barre? | ☐ | ☐ | ☐ |
| 6. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g. Diabetes), anemia, or other blood disorder? | ☐ | ☐ | ☐ |
| 7. Do you have cancer, leukemia, rheumatoid arthritis, HIV/AIDS, ankylosing spondylitis, Crohn's disease or any other immune system problem? | ☐ | ☐ | ☐ |
| 8. Do you have a weakened immune system or in past 3 months, taken medication that weaken it such as cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments? | ☐ | ☐ | ☐ |
| 9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? | ☐ | ☐ | ☐ |
| 10. For WOMEN, are you pregnant or is there a chance you could become pregnant during the next month? | ☐ | ☐ | ☐ |
| 11. Have you received any vaccination or TB skin test in the past 4 weeks? | ☐ | ☐ | ☐ |

I have read the Vaccine Information Sheet or fact sheet about the corresponding vaccine(s) I am receiving. I have had a chance to ask questions to my satisfaction. I understand the benefits and risks of the vaccine and request that the vaccine be given to me or to the person named above for whom I am authorized to make the request. I authorize the release of any medical information or other information necessary to process an insurance claim. I understand that if applicable, Specialty RX (Citywide RX LLC) will submit my claim to insurances they contract with. I certify that all Medicare information given to Specialty RX (Citywide RX LLC) Pharmacy is true. Specialty Rx (Citywide RX LLC) has made their "Notice of Privacy Practices" available to me. I authorized the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid, the HRSA COVID-19 program for the uninsured, or other third party payer as needed and request payment of authorized benefits to be made on my behalf to Specialty RX (Citywide RX LLC) Pharmacy. I acknowledge that my vaccination record may be shared with federal or state or city agencies for registry reporting. I agree to stay in the general area for at least fifteen (15) minutes after receiving my vaccination for any potential adverse reactions. I understand if I experience side effects that I should contact a doctor, pharmacy, call 911 if an emergency.



SIGNATURE OF PATIENT TO RECEIVE VACCINE (OR PARENT, GUARDIAN, OR AUTHORIZED REPRESENTATIVE — DATE

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

NAME OF PARENT, GUARDIAN, OR AUTHORIZED REPRESENTATIVE — RELATIONSHIP — PHONE NUMBER

## OFFICIAL USE ONLY:

☐ L ☐ R

| VACCINE | MANUFACTURER | | INJECTION SITE |
|---|---|---|---|
| LOT# | EXP. DATE | | ADMINISTRATION DATE |
| ROUTE | SITE | VOLUME (mL) | |
| ADMINISTERED BY: | | | |
| LICENSE# | | | SIGNATURE OF VACCINATOR WHO ADMINISTERED VACCINE(S) AND PROVIDED VIS |