COVID-19 VACCINE INFORMED CONSENT FORM

PATIENT INFORMATION

Full Name (First MI Last): _____ Date of Birth: _____ Age: _____

Email: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Gender: ☐ Male ☐ Female Race: _____ Ethnicity: _____

Primary Care Doctor: _____ City/State: _____

How many vaccine doses have you received? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Other _____ Date of last dose: _____

If 1+ doses, which vaccine did you get for your last dose? ☐ Pfizer (12+) ☐ Pfizer Pediatric (5-11) ☐ Pfizer Young Pediatric (6mo-4yr) ☐ Moderna (12+) ☐ Moderna Pediatric (6-11) ☐ Moderna Young Pediatric (6mo-5yr) ☐ Janssen (18+) ☐ Novavax (12+) ☐ Other

If this is your first dose, which vaccine would you prefer to receive? ☐ Pfizer ☐ Moderna ☐ Janssen

Are you immunocompromised? Please mark any of the following conditions that you have:

- ☐ I have been receiving active cancer treatment for tumors or cancers of the blood
- ☐ I have received an organ transplant and am taking medicine to suppress the immune system
- ☐ I have received a stem cell transplant within the last 2 years or am taking medicine to suppress the immune system
- ☐ I have moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
- ☐ I have advanced or untreated HIV infection
- ☐ I have active treatment with high-dose corticosteroids or other drugs that may suppress my immune response
- ☐ None of the above

If you marked any of the conditions above and…

have received *two* doses total of Pfizer or Moderna COVID-19 vaccine, a third dose is recommended at least 28 days after the date of your last dose. If you received Pfizer Young Pediatric (6mo-4yr), the third dose will be after at least 8 weeks, not 28 days. You should receive the vaccine from the same manufacturer as you received for your first two doses as part of your primary series.

have received *three* doses of Pfizer COVID-19 vaccine AND are 5 to 11 years, a booster dose of Pfizer is recommended at least 3 months after the date of your last dose.

If you marked "None of the above" and have received *two* doses total of Pfizer COVID-19 vaccine AND are 5 to 11 years, a booster dose of Pfizer is recommended at least 5 months after the date of your last dose.

****NOTE****

The FDA authorized one dose of the updated booster for anyone who has finished their primary series of Pfizer (12+), Moderna (12+), Novavax (12+), or Janssen (18+). This overrides previous booster recommendations.

If you have completed your primary series (1 dose of Janssen, 2 doses of Novavax, 2 doses of Moderna or Pfizer if not immunocompromised, or 3 doses of Moderna or Pfizer if immunocompromised) **and are 12 years or older,** an updated booster dose is recommended at least 2 months after the date of your last dose. Your last dose can be part of the primary series or a previously authorized booster dose.

Which booster vaccine would you prefer to receive? ☐ Pfizer (12+) ☐ Moderna (18+)

Are you planning to get another vaccine at this time? ☐ Yes ☐ No

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SCREENING QUESTIONS: Pleast select the correct option below.

	YES	NO	Don't Know or N/A
Do you feel sick today?			
Have you had COVID-19 within the last three months?			
Do you have a history of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparininduced thrombocytopenia (HIT)?			
Do you have a history of thrombosis with thrombocytopenia syndrome (TTS)?			
Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?			
Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?			
Do you have an allergy to any food, medication or vaccine? If so, please specify allergy:_____			
Have you ever had a serious reaction or fainted after receiving any vaccination?			
Do you carry an EpiPen?			
Do you have a bleeding disorder or take a blood thinner?			
Have you ever had a seizure, brain disorder, or Guillain-Barre Syndrome?			
Do you have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies?			
Do you have a history of myocarditis or pericarditis?			
Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?			
FOR WOMEN: Are you currently pregnant or breastfeeding?			

INSURANCE INFORMATION

☐ I hereby authorize the pharmacy to bill my insurance on my behalf for the COVID-19 vaccine administration fee & receive payment.

Insurer: _____ Member #: _____

Rx Group: _____ BIN #: _____ PCN #: _____

☐ If you do not have insurance, please provide your Social Security Number or Driver's License: _____

ACKNOWLEDGEMENTS

☐ I attest that the answers provided here are accurate to the best of my knowledge.

☐ I understand the benefits and risks of the vaccination(s) as described in the Vaccine Information Sheet (VIS) or Emergency Use Authorization (EUA), a copy of which I was provided with this Consent & Release. 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 & Release.

☐ I have received a copy of the notice of Privacy Practices. I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the pharmacy & of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Signature of Patient to Receive Vaccine
(or Signature of Power of Attorney or Legal Guardian) _____ Date: _____

Parent/Guardian Name: _____ Relationship to patient: _____

PHARMACY USE ONLY

BRAND/MFG	DOSAGE	ROUTE	SITE	EUA /VIS	LOT	EXP. DATE	STATUS
☐ Pfizer Monovalent ☐ 6mo-4yr ☐ 5-11 ☐ 12+		IM	R or L Arm or Thigh				☐ Billed
☐ Moderna Monovalent ☐ 6mo-5yr ☐ 6-11 ☐ 12+		IM	R or L Arm or Thigh				☐ PA Siis
☐ Pfizer Bivalent (12+)	0.3mL	IM	R or L Arm	08/31/22			
☐ Moderna Bivalent (18+)	0.5mL	IM	R or L Arm	08/31/22			☐ Fax PCP
☐ J&J (18+)	0.5mL	IM	R or L Arm	05/05/22			
☐ Novavax (18+)	0.5mL	IM	R or L Arm	08/19/22			☐ Scanned

Signature of Pharmacist who administered_____**Date Administered:**_____