COVID Vaccine Intake Consent Form

Manufacturer/Dose #

| Age12+ Pfizer 1st☐ | | Age12+ Pfizer 2nd☐ | | Age12+ Pfizer Booster☐ | | Pfizer 3rd(immunocomp.)☐ |

| Age 5-11 Pfizer 1st ☐ | | Age 5-11 Pfizer 2nd ☐ | | Age 5-11 Pfizer Booster ☐ |

| Moderna 1st ☐ | | Moderna 2nd ☐ | | Moderna Booster ☐ | | Moderna 3rd (immunocompromised) ☐ |

| Johnson & Johnson 1st ☐ | | Johnson & Johnson 2nd ☐ |

Patient Information

Last Name _____ First Name _____

Date of Birth _____ Gender _____ Phone Number _____ Email Address _____

Address _____ City _____ State _____ Zip _____ SSN _____

Primary Care Provider Name (PCP) _____ PCP Phone # _____ PCP Fax # _____

PCP Address _____ City _____ State _____ Zip _____

Prescription Insurance

☐ Patient is primary card holder (check box if yes)

Pharmacy Insurance Provider _____ ID# _____ Group _____ BIN _____ PCN _____

Medicare Fields: (Note: COVID Vaccine will be billed at Part B through your Medicare provider)

☐ Yes ☐No

Is the patient age 65 or older or is the patient Medicare Eligible? _____ Medicare Part B Number (red, white, and blue card) _____

Medical Insurance:

☐ Yes ☐No

Medical Insurance Provider _____ ID# _____ Group _____ Is the Patient the Primary Cardholder? _____

COVID-19 Screening Questions		Yes	No	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?	☐	☐	☐

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COVID-19 Screening Questions (continued)		Yes	No	Don't Know
3.	Do you currently or have you in the past 14 days had a fever, cough, shortness of breath, or loss of sense of taste and smell	☐	☐	☐
4.	Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	☐	☐	☐
5.	Do you take anticoagulation medication? For example: warfarin, Coumadin, or other blood thinner.	☐	☐	☐
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, HIV/AIDS, rheumatoid arthritis, 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 medications 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 vaccinations or TB skin test in the past 4 weeks?	☐	☐	☐

CONSENT FOR SERVICES: I attest that I am eligible to receive either a 1st, 2nd, or 3rd dose as per current CDC/FDA guidelines. I have been provided with the Vaccine Information Sheet(s) 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 Mainline Pharmacy/Bushy Run Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid 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 Mainline Pharmacy/Bushy Run 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 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 Mainline Pharmacy will use and disclose my health information as set forth in the Mainline Pharmacy/Bushy Run Pharmacy Notice of Privacy Practices (copy is available in-store). Vaccine Clinics: If I am receiving a vaccine through a vaccine clinic, I understand that my name, vaccine appointment date and time will be provided to the clinic coordinator.

X

Signature of patient to receive vaccine or person authorized to make the request Date

Vaccine Administration Information for immunizer/Pharmacist use only

Administration Date	Vaccine	VIS Date	Manufacturer

Lot#	Exp. Date	Route	Site	Volume (ml)

Administering Immunizer Name & Title Administering Immunizer Signature