COVID-19 INFORMED CONSENT FORM | NORLAND AVENUE PHARMACY

PATIENT INFORMATION

First Name: _____ Last Name: _____

Email: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Gender: ☐ Male ☐ Female Date of Birth: _____ Age: _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Prefer not to answer

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian
☐ Native Hawaiian/Other Pacific Islander ☐ Prefer not to answer ☐ Other: _____

Primary Care Doctor: _____ City/State: _____

Are you one of the following? ☐ Essential Worker ☐ First Responder ☐ Healthcare Worker
☐ Person with Chronic Condition ☐ Resident of a Care Facility or Other Group Setting ☐ No, I am none of these

Which dose of COVID-19 vaccine will this be? ☐ First ☐ Second ☐ Third

If Second, Date of First Dose: _____ If Third, Date of Second Dose: _____

If Third, which criteria do you meet? ☐ Immunocompromised ☐ Booster

Which vaccine did you receive? ☐ Pfizer ☐ Moderna ☐ Other _____

INSURANCE INFORMATION: Fill the appropriate category.

☐ **Medicaid:** Provider: _____ Policy/Member ID #: _____

Medicaid #: _____ Group #:_____

☐ **Medicare Part B:**

Subscriber ID #: _____ Responsible Party: _____

Policy Holder's Date of Birth: _____

☐ **Private Insurance:** Insurer: _____ Subscriber ID: _____

Bin #: _____ PCN: _____ Group #: _____

☐ **No Insurance:** To have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for uninsured patients, please provide one of the following:

Social Security #: _____

State Identification #: _____ State of Issuance: _____

Driver's License #: _____ State of Issuance: _____

I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA), a copy of which I was provided with this Consent and 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, an individual for whom I represent and for whom I am authorized to sign this Consent and Release. I fully release and discharge Norland Avenue Pharmacy, affiliates, and their employees from any liability for illness, injury, loss, or damage which may result there from.

If guarantor/guardian, indicate your relationship to the recipient: _____

Signature: _____

Print: _____ Date of Signature: _____

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 and 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 Acknowledgement of Notice of Privacy Practices

_____

Patient First Name: _____ Patient Last Name: _____

SCREENING QUESTIONNAIRE

	YES	NO	N/A
Do you feel sick today?			
Have you ever had an allergic reaction to 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? *			
Have you ever had an allergic reaction to polysorbate? *			
Have you ever had an allergic reaction to a previous dose of COVID-19 vaccine? *			
Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? *			
Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.			
Do you have any drug allergies?			
Have you received any vaccine in the last 14 days?			
Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
Do you have a bleeding disorder or are you taking a blood thinner?			
FOR WOMEN: Are you pregnant or considering becoming pregnant in the next 60 days?			

***** 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.

List any drug allergies: _____

Please explain any other "Yes" answers provided above:

_____

_____

FOR PHARMACY USE ONLY

- ☐ Pharmacist has reviewed the Patient Information & Screening Questionnaire with the patient, and they have indicated that all answers are accurate as of the day of vaccine administration.
- ☐ Pharmacist has screened, when appropriate, for contradictions to vaccine.
- ☐ Pharmacist has asked that the patient stay for the appropriate amount of time after administration of vaccine.

Vaccine Manufacturer: _____

Lot Number: _____

Time Given: _____

Site of Administration: ☐ Left Deltoid ☐ Right Deltoid

NDC: _____

Expiration Date: _____

Date Given: _____

Given By: _____

Pharmacist Signature: _____

Pharmacist Name (print): _____

Pharmacy Tech Signature: _____

Pharmacy Tech Name (print): _____