SpecialtyRx

COVID VACCINE CONSENT FORM 4.1

FACILITY INFORMATION:

FACILITY/CLINIC LOCATION NAME *REQUIRED | TELEPHONE

ADDRESS | CITY | STATE | ZIP

PATIENT INFORMATION:

ARE YOU A RESIDENT OR STAFF OF THE FACILITY? *REQUIRED ☐ RESIDENT ☐ STAFF/NON-RESIDENT

LAST NAME *REQUIRED | FIRST NAME *REQUIRED | DATE OF BIRTH *REQUIRED | GENDER *REQUIRED

ADDRESS *REQUIRED | CITY*REQUIRED | STATE*REQUIRED | ZIP*REQUIRED | COUNTY*REQUIRED

PHONE NUMBER *REQUIRED

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

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

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

PRIMARY CARDHOLDER NAME:

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

DOSE INDICATION:

>>ARE YOU MODERATELY OR SEVERELY IMMUNOCOMPROMISED? ***if not, skip to "FOR ALL OTHER INDIVIDUALS..."***

☐ YES, I am moderately or severely immunocompromised due to one or more of the medical conditions or receipt of immunosuppressive medications or treatments listed below:

1) Active treatment for solid tumor and hematologic malignancies, 2) Receipt of solid-organ transplant and taking immunosuppressive therapy, 3) Receipt of CAR-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy), 4) Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome), 5) Advanced or untreated HIV infection, 6) Active treatment with high-dose corticosteroids (i.e., 8805;20mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory

☐ This is my **FIRST** DOSE.

☐ This is my **SECOND** DOSE.

☐ This is my **THIRD** DOSE.
I attest that it has been at least 28 days since my 2nd dose of Pfizer (Comirnaty) or Moderna (Spikevax)

☐ This is my **BOOSTER** DOSE
I attest I received Pfizer (Comirnaty) or Moderna (Spikevax) at least 3 months prior to today OR I attest I received J&J(Janssen) at least 2 months prior to today.

☐ This is my **2nd BOOSTER** DOSE
I attest I received Pfizer (Comirnaty) or Moderna (Spikevax) or J&J(Janssen) booster at least 4 months prior to today.

>>FOR ALL OTHER INDIVIDUALS ***[PFIZER: AGES >12; MODERNA OR JANSSEN: AGES >18]***

☐ This is my **FIRST** DOSE.

☐ This is my **SECOND** DOSE.

☐ This is my **BOOSTER** DOSE.
I attest it has been at least 5 months since I completed the primary 2-dose series of Pfizer (Comirnaty) or Moderna (Spikevax)
OR I attest it has been at least 2 months since I received J&J (Janssen).

☐ This is my **2nd BOOSTER** DOSE
I attest I received Pfizer (Comirnaty) or Moderna (Spikevax) or J&J(Janssen) booster at least 4 months prior to today.

! My previous dose date(s) are:	DATE OF DOSE 1	DATE OF DOSE 2	DATE OF DOSE 3
	☐ Pfizer (Comirnaty) ☐ Moderna (Spikevax) ☐ J&J (Janssen)	☐ Pfizer (Comirnaty) ☐ Moderna (Spikevax) ☐ J&J (Janssen)	☐ Pfizer (Comirnaty) ☐ Moderna (Spikevax) ☐ J&J (Janssen)

★ Patient Temperature: | Date:

PATIENT'S LAST NAME DATE OF BIRTH

COVID-19 SCREENING QUESTIONS	YES	NO	I DON'T KNOW
1. In the past 10 days, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?	☐	☐	☐
2. In the past 10 days, have you had contact with anyone who tested positive for COVID-19?	☐	☐	☐
3. Have you had the 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?	☐	☐	☐

IMMUNIZATION SCREENING QUESTIONS	YES	NO	I DON'T KNOW
*1. Are you sick today? For example: cold, fever, acute illness? ***(If yes, exercise caution. Vaccine might be contraindicated or need consultation with a prescriber)***	☐	☐	☐
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 or covid 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? ***(If yes, exercise caution. Vaccine might be contraindicated or need consultation with a prescriber)***	☐	☐	☐
4. Do you take anticoagulation medication (Coumadin/warfarin or other blood thinner) or have a history of a bleeding disorder/ blood clots?	☐	☐	☐
*5. Have you had a seizure or a brain or other nervous system problem or Gillian Barre? ***(If yes, take caution with J&J (Janssen) Vaccine).***	☐	☐	☐
6. Do you have cancer, leukemia, rheumatoid arthritis, HIV/AIDS, ankylosing spondylitis, Crohn's disease or any other immune system problem?	☐	☐	☐
7. 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?	☐	☐	☐
*8. Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart? ***(If yes, avoid subsequent mRNA dose is it occurred after the first dose of mRNA)***	☐	☐	☐
*9. Do you have a history of TTS (Thrombosis with Thrombocytopenia Syndrome) or TTS following JJ (Janssen) covid vaccine? ***(If yes, DO NOT USE J&J(Janssen). Use mRNA vaccine only)***	☐	☐	☐
10. For WOMEN, are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐

****J&J (JANSSEN) RECIPIENTS ONLY: ☐ By checking this box, I attest that I was made aware of the potential side effects from the Janssen vaccination, and was provided information about the vaccine. I am aware that mRNA vaccines are preferred, but choose to receive the JJ (Janssen) vaccine.****

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 will submit my claim to insurances they contract with. I certify that all Medicare information given to Specialty RX Pharmacy is true. Specialty Rx 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 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:

☐ Pfizer (Comirnaty) 0.3mL ☐ Moderna (Spikevax) 0.5mL ☐ Moderna (Spikevax) 0.25mL

☐ J&J (Janssen) 0.5mL ***See ** J&J(JANSSEN) RECIPIENTS ONLY ATTESTATION*** above***

ADMINISTRATION DATE

LOT# EXP. DATE

VACCINATOR NAME (PLEASE PRINT) LICENSE#

ROUTE: Intramuscular SITE: ☐ **LT DELTOID** ☐ **RT DELTOID**

SIGNATURE OF VACCINATOR WHO ADMINISTERED VACCINE(S) AND PROVIDED VIS