SpecialtyRx

# COVID VACCINE CONSENT FORM 7.0

## 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 Bridge Access Program / VFA 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:

***TODAY, I AM:***

☐ Age 5-11 ☐ Age 12 and Over

*Are you immunocompromised?

☐ YES ☐ NO

***THIS DOSE IS FOR MY***

☐ 1ST DOSE
*(I am currently unvaccinated – I have never received any previous Covid vaccine doses at all)*

☐ 2ND or 3RD DOSE
*(This will be my 2nd dose to complete primary vaccination series OR for my 3rd dose designated for the immunocompromised only)*
**must be given at least 4 weeks since last dose*

☐ BOOSTER DOSE
*(I have taken previous Covid Vaccine doses)*
**must be given at least 2 months since last dose*

☐ ADDITIONAL DOSE
*(I am immunocompromised and this will be an additional recommended dose)*
**must be given at least 2 months since last dose*

## IF BOOSTER, MY PREVIOUS DOSE DATE(S) WERE:

***PRIMARY SERIES***

| *DOSE 1:* | | *DOSE 2:* | | *DOSE 3 (Immunocompromised):* | |
|---|---|---|---|---|---|
| | ☐Pfizer ☐Moderna ☐J&J | | ☐Pfizer ☐Moderna | | ☐Pfizer ☐Moderna ☐J&J |

***BOOSTERS***

| 1. | | 2. | | 3. | |
|---|---|---|---|---|---|
| | ☐Pfizer ☐Moderna ☐J&J ☐Novavax | | ☐Pfizer ☐Moderna ☐Novavax | | ☐Pfizer ☐Moderna ☐Novavax |
| **4.** | ☐Pfizer ☐Moderna ☐Novavax | **5.** | ☐Pfizer ☐Moderna ☐Novavax | **6.** | ☐Pfizer ☐Moderna ☐Novavax |

★ 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. Do you have cancer, leukemia, rheumatoid arthritis, HIV/AIDS, ankylosing spondylitis, Crohn's disease or any other immune system problem? | ☐ | ☐ | ☐ |
| 6. 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? | ☐ | ☐ | ☐ |
| 7. 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)*** | ☐ | ☐ | ☐ |
| 8. For WOMEN, are you pregnant or is there a chance you could become pregnant during the next month? | ☐ | ☐ | ☐ |

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 *(To be completed by the vaccinator)*

☐ Pfizer (Fall 23-24) ☐ Moderna (Fall 23-24)

☐ Prefilled Syringe ☐ Vial

☐ 0.2 mL ☐ 0.3 mL ☐ 0.5 mL ☐ 0.25 mL

LOT# EXP. DATE:

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

ADMINISTRATION DATE

VACCINATOR NAME (PLEASE PRINT) LICENSE#

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

☐ **DECLINATION STATEMENT:** I wish to *REFUSE* the COVID-19 vaccination (or refuse for the person named above for whom I am authorized to make this request. I acknowledge that I have read or had explained to me, the Coronavirus Disease (COVID-19) General Information handout and the Emergency Use Authorization (EUA) Fact sheets regarding the vaccine. I have had the opportunity to ask question, which have been answered to my satisfaction and understand the benefits and risks of the vaccination as describer. I understand that if I decline the vaccine, I may change my mind and request to be vaccinated at a later date, with the understanding that the vaccination will be based on the availability at that time.

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