COVID-19 INFORMED CONSENT FORM

LEWISVILLE DRUG
PHARMACY&WELLNESSCENTER

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: _____

Have you had any doses of COVID-19 vaccine previously? ☐ Yes ☐ No Date of last dose: _____ Number of doses received: ____

If 1+ doses, which vaccine did you get for your last dose? ☐ Pfizer ☐ Moderna ☐ Janssen ☐ Novavax ☐ Other: _____

You are eligible for a bivalent dose if any of the below are true:

- ☐ You have never received a COVID-19 vaccine
- ☐ You have never received a bivalent dose **and** it has been at least 2 months since your last dose
- ☐ You are 65 years or older **and** it has been at least 4 months since your first bivalent dose
- ☐ You are immunocompromised **and** it has been at least 2 months since your first bivalent dose (see below for qualifications)

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

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: _____

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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?			
Have you received any immunizations in the past 4 weeks? Please specify: _____			
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 disorder, brain disorder, or Guillain-Barre Syndrome?			
Do you have a weakened immune system (i.e., HIV infection, cancer), history of a transplant, 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?			
During the past year, have you received a transfusion of blood or blood products or been given a medicine called immune (gamma) globulin or an antiviral drug?			
Do you have a long-term health problem with heart, lung, kidney, diabetes, asthma, no spleen, cochlear implant, anemia or a blood/bleeding disorder? If yes, please specify: _____			
FOR WOMEN: Are you pregnant or are you planning on becoming pregnant during the next month?			
FOR THOSE 50+: Have you had a shingles vaccination or been diagnosed with shingles in last 12 months?			
FOR THOSE 65+: Have you ever had a pneumococcal vaccination?			

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 Bivalent ☐ 5-11 ☐ 12+	☐ 0.3mL ☐ 0.2mL	IM	R or L Arm or Thigh	04/18/23			☐ Billed ☐ Fax PCP ☐ Scanned
☐ Moderna Bivalent ☐ 6-11 ☐ 12+	☐ 0.5mL ☐ 0.25mL ☐ 0.2mL	IM	R or L Arm or Thigh	04/18/23			

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