# COVID-19 VACCINE INFORMED CONSENT FORM

LEWISVILLE DRUG
PHARMACY & WELLNESS CENTER

## 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: _____

How many doses of COVID-19 vaccine have you received? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ Other _____ Date of last dose: _____

**If 1+ doses**, which original vaccine did you receive? ☐ Pfizer (12+) ☐ Pfizer Pediatric (5-11) ☐ Moderna ☐ Janssen ☐ Other

**If this is your first dose**, which vaccine would you prefer to receive? ☐ Pfizer ☐ Moderna ☐ Janssen

**If you received Janssen and are getting a booster dose**, which vaccine would you prefer to receive? ☐ Pfizer ☐ Moderna

## FOR THOSE WHO HAVE RECEIVED TWO DOSES OF PFIZER (12+) OR MODERNA

**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

## FOR THOSE WHO ARE IMMUNOCOMPROMISED

**If you have received two doses total of COVID-19 vaccine**, a third dose is recommended at least 28 days after the date of the second dose. You will receive the vaccine from the same manufacturer as you received for your primary series.

**If you have received three doses of COVID-19 vaccine**, a booster dose is recommended at least 3 months after the date of your last dose. Depending on your age, you may choose which manufacturer's vaccine you would like to receive for the booster dose. Pfizer is approved for those 12 or older; Moderna is approved for those 18 or older.

Which booster vaccine would you prefer to receive? ☐ Pfizer ☐ Moderna

**If you have received your booster dose of COVID-19 vaccine**, you are eligible to receive a second booster dose at least 4 months after the date of your last dose. Depending on your age, you may choose which manufacturer's vaccine you would like to receive for the booster dose. Pfizer is approved for those 12 or older; Moderna is approved for those 18 or older.

Which booster vaccine would you prefer to receive? ☐ Pfizer ☐ Moderna

## FOR THOSE WHO ARE NOT IMMUNOCOMPROMISED

**If you have received two doses total of COVID-19 vaccine**, a booster dose is recommended at least 5 months after the date of your last dose. Depending on your age, you may choose which manufacturer's vaccine you would like to receive for the booster dose. Pfizer is approved for those 12 or older; Moderna is approved for those 18 or older.

Which booster vaccine would you prefer to receive? ☐ Pfizer ☐ Moderna

**If you have received your booster dose of COVID-19 vaccine AND are 50 years or older**, you are eligible to receive a second booster dose at least 4 months after the date of your last dose.

Which booster vaccine would you prefer to receive? ☐ Pfizer ☐ Moderna

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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? | | | |
| In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19? | | | |
| In the past two weeks, have you had a known exposure with anyone who tested positive for COVID-19? | | | |
| 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?<br>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, brain disorder, or Guillain-Barre Syndrome? | | | |
| Do you have a weakened immune system (i.e., HIV infection, cancer) 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? | | | |
| **FOR WOMEN:** Are you currently pregnant or breastfeeding? | | | |

## 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: _____

## 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

| VACCINE | BRAND/MFG | DOSAGE | ROUTE | SITE | EUA /VIS | LOT | EXP. DATE |
|---|---|---|---|---|---|---|---|
| COVID-19 | ☐ Moderna | | | | | | |
| COVID-19 | ☐ Pfizer (12+) | | | | | | |
| COVID-19 | ☐ J&J | | | | | | |
| COVID-19 | ☐ Pfizer (5-11) | | | | | | |

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