COVID Vaccine Screening Questionnaire & Consent Form

PATIENT INFORMATION			
First Name:	**Last Name:**	**DOB:**	**Age:**
Address:	**City:**	**State:**	**Zip Code:**
Insurance: Private / Medicare Part B / None **Medicare #** (Red/White/Blue Card):		**SSN:** **Phone #:**	

Please Circle:

Gender: Female / Male / Other

Race: Asian / Black or African-American / White / American Indian or Alaskan Native / Native Hawaiian or Pacific Islander

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Unknown

SCREENING QUESTIONS			
1. Are you feeling sick today?	Yes	No	Unsure
2. Have you ever received a dose of COVID-19 vaccine? a. Which shot would you like today? i. Primary Series (1st dose): ☐ Pfizer (12+ years old) ☐ Moderna (6+ years old) ii. Bivalent Booster: ☐ Pfizer (12+ years old) ☐ Moderna (5+ years old)	Yes	No	Unsure
3. Have you ever had an allergic reaction to a component of COVID-19 vaccine, including: a. Polyethylene glycol (PEG) -- found in some medications, such as laxatives & colonoscopy preparations b. Polysorbate which is found in some vaccines, film coated tablets, and intravenous steroids	Yes	No	Unsure
4. Have you ever had an allergic reaction to another vaccine (*other* than COVID-19) or an injectable medication?	Yes	No	Unsure

5. **Check all that apply to you:**
   - ☐ History of myocarditis or pericarditis
   - ☐ Severe allergic reaction to something other than a vaccine or injectable therapy (food, pet, venom, environmental, or oral medications
   - ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
   - ☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
     - **If yes, please initial here: _____**
   - ☐ Have a bleeding disorder or take a blood thinner
   - ☐ Have a history of heparin-induced thrombocytopenia (HIT)
   - ☐ History of Guillain-Barré Syndrome (GBS)

6. In which arm would you like to receive your vaccine? **LEFT / RIGHT**

AUTHORIZATION / SIGNATURE

By signing below, you acknowledge the following: The Food and Drug Administration has approved the vaccine being administered to you on an emergency use basis as a vaccination for SARS-CoV-2 (Coronavirus or COVID-19), after having found it to be safe and effective in accordance with Emergency Use Authorization requirements. Information about the vaccine has been made available to you in the form of the Emergency Use Authorization (EUA) Fact Sheet/VIS form. The vaccine being administered to you is not guaranteed to keep you from getting COVID-19. You may experience an adverse, even unexpected, reaction to it, including, without limitation, all or some of the signs and symptoms listed on the Vaccine Information Sheet. You are making an informed decision to receive the vaccine. You fully release and discharge Prosperity Drug Co, its affiliates and assigns, and its officers, and employees from any illness, injury, loss, or damage that may result from the administration of the vaccine. You also agree to wait in the vaccination area for 15-30 minutes for monitoring and to receive treatment in case of adverse reactions. Your insurance company will be billed for the administration of the vaccine and any additional services provided in the event of an adverse reaction. Should you experience any symptoms, such as, without limitation, a fever of more than 101.5 F, fatigue, chills, headache, myalgia, or pain at the injection site, please contact your healthcare provider as soon as possible. If it is an emergency, please go to your nearest emergency medical provider if it can be done safely or contact 9-1-1.

I acknowledge that I have had an opportunity to read, understand and ask questions about the vaccine and the COVID-19 Vaccine Emergency Use Authorization (EUA) Fact Sheets/VIS relating to the vaccine I will be receiving, and I accept all risks associated with such. I authorize Prosperity Drug Co. to release all information necessary to process my claims and provide the services above.

Signature (patient / legal guardian): _____ Date: _____

FOR PHARMACY USE ONLY

Pfizer Bivalent ● 0.3 mL ● IM (Left / Right) Lot #: _____ | Exp: _____	**Moderna Bivalent** ● 0.5 mL ● IM (Left / Right) Lot #: _____ | Exp: _____

Administered by:

RPh: D. Crawford (42645) / K. Kibler (43575) / M. Montgomery (12640) / L. Kyzer (11418) / C. Monts (11465) / Other: _____

Interns: A. Crayne (48491) / A. Livingston (47005) / Other: _____

Signature:_____ **Date:** _____