COVID IMMUNIZATION CONSENT FORM

LAST Name: _____
First Name: _____ **Middle Initial:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____ **DOB (m/d/y):** ____/____/_____ **Age:** _____ **Sex (M/F):** _____
Vaccine To Be Received ☐ **Pfizer** ☐ **Moderna** ☐ **Novavax**

For vaccine recipients: The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	YES	NO	NOT SURE
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Novavax ☐ Johnson&Johnson ☐ Another product_____			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of a COVID-19 vaccine including either of the following:			
○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
○ Polysorbate, found in some vaccines, film coated tablets, and intravenous steroids.			
• Have you had an allergic reaction to a previous dose of COVID-19 vaccine.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 Vaccine component, but it is not known which component elicited the immediate reaction.			
4. Have you ever had an allergic reaction to another **vaccine** (other than COVID-19 vaccine) or an **injectable medication**? **VACCINE ALLERGIES** _____ (A severe allergic reaction [e.g., anaphylaxis] that required epinephrine or EpiPen® or to go to the hospital. It also includes an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something **other than** a component of vaccine or injectable medication? **NON-VACCINE ALLERGIES** _____ This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days? If yes, which vaccine _____			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? If yes, when was the positive test _____			
8. Have you received Monoclonal Antibodies or Convalescent Serum as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner? If yes, which one applies: ☐ Bleeding Disorder ☐ Blood Thinners			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers? (A cosmetic procedure that injects gels under the skin to reduce lines)			
13. Do you have a history of Thrombocytopenia or any other Platelet disorders?			
14. Have you ever fainted or felt extreme dizziness after receiving an immunization/vaccination?			

ADVERSE REACTIONS

Side effects that have been reported with the COVID-19 Vaccines include:

• Injection site reactions: pain, tenderness and swelling of the lymph nodes in the same arm of the injection, swelling (hardness), and redness

• General side effects: fatigue, headache, muscle pain, joint pain, chills, nausea and vomiting, and fever

There is a remote chance that the COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes after getting a dose of the COVID-19 Vaccine. For this reason, the provider may ask you to stay for monitoring after vaccination. Signs of a severe allergic reaction can include: • Difficulty breathing • Swelling of your face and throat • A fast heartbeat • A bad rash all over your body • Dizziness and weakness. Serious and unexpected side effects may occur. The COVID-19 Vaccines are still being studied in clinical trials. These are not all the possible side effects of the COVID-19 Vaccine.

Which Covid-19 Vaccine are you receiving today?
☐ 1st Dose ☐ 2nd Dose ☐ Booster Dose

By checking the box I attest I am eligible based on current guidelines.

Name of Primary Care Physician (PCP): _____

City and State of Office Location: _____

Vaccine Information Sheet (VIS): **Publication Date:** _____

Patient Receipt Date: _____

CONSENT FOR SERVICES, MEDICAL RECORDS and HIPAA PRIVACY INFORMATION

I have read the adverse reactions associated with the influenza and pneumococcal vaccines. A copy of the Vaccine Information Sheet has been provided to me. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result. My medical record may be shared with my physician/insurance. I am requesting that the immunization(s) be given to me or the person named below for whom I am the legal guardian. I, for myself, my heirs, executors, personal representatives and assigns, hereby release the Rock Hill Pharmacy and its employees, from any and all claims arising out of, in connection with or in any way related to my receipt of this or these immunization(s). Rock Hill Pharmacy and the aforementioned parties shall not at any time or to any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. The Rock Hill Pharmacy will use and disclose your personal and health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY AND CONFIDENTIALITY PRACTICES** to help you better understand our policies in regards to your personal health information. I acknowledge that I have received a copy of the Notice of Privacy and Confidentiality Practices.

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Consent

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described. I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

X _____ _____

Signature/Legal Guardian — Date

_____ _____

Print Name — Printed Name of Minor (If Signing for Minor)

Medicare Beneficiaries ONLY

I understand that I am giving Rock Hill Pharmacy permission to ask for Medicare payments for my medical care, including supplies and equipment. I understand that Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare and the companies that handle Medicare payment requests.

I understand that the Centers for Medicare & Medicaid Services (CMS) is the government's Medicare agency. I understand that a copy of this release is as valid as the original document. Furthermore, I understand that I am responsible for paying any deductible or co-insurance amounts. Therefore, I ask that payment of authorized Medicare benefits be made to either me or on my behalf to Rock Hill Pharmacy for any services or items furnished to me by Rock Hill Pharmacy. I authorized any holder of medical or other information about me to release such information to the Centers for Medicare & Medicaid Services (CMS) and its agents as needed to determine these benefits or benefits for related services.

I have received a copy of the Medicare Supplier Standards.

X _____ _____

Signature of Beneficiary — Date

_____ _____

Print Name — HICN

PHARMACY USE ONLY _____

Immunizer's Signature

Manufacture: _____ Site of Injection: R / L Deltoid IM

Lot: _____ Expiration: _____