WEST SIDE PHARMACY COVID-19 VACCINE IMMUNIZATION CONSENT FORM

(Legal) First Name: _____ **MI:** _____ **Last Name:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____ **Phone Number:** _____ **Gender:** Male / Female

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ American Indian ☐ Pacific Islander ☐ Other

MEDICAL HISTORY

Please complete the following questions for the individual receiving the vaccine. If you answer "YES", you *may* not be able to receive the vaccine.

**If YES and further guidance is needed, Refer to Pfizer website at www.PfizerMedInfo.com or call 1-800-438-1985 for vaccine information on vaccine temperature excursions, efficacy, safety, stability, dosage, vaccine ingredients, mechanism of action and administration. For overview for Vaccination Providers about Moderna COVID-19 vaccine refer to www.modernatx.com or call 1-866-MODERNA.*	***YES**	**NO**
Have you had a previous COVID-19 Vaccine? If yes, date? _____		
Have you had any vaccines within the previous 14 days? Pfizer-BioNTech or Moderna COVID-19 vaccine should be administered alone with minimal interval of 14 days before or after any other vaccine.		
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?		
Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component or injectable therapy? Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness.		
Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive COVID-19 vaccine, a discussion with your healthcare provider can help make informed decision.		
Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe obesity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive COVID-19 vaccine unless otherwise contraindicated.		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Vaccination should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced immune responses.		
NOTE: A second dose of COVID-19 vaccine is due ~21 days after initial Pfizer Vaccine and ~28 days after initial Moderna Vaccine. Refer to your COVID-19 vaccination record card for second dose due date. **Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date.**		

RELEASE AND ASSIGNMENT

- I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient Emergency Use Authorization Fact Sheet for each vaccine visit the website www.cvdvaccine.com to view current EUA: or you may also visit the Local Health Unit or private provider to receive a printed copy of the EUA Fact Sheet.
- I give consent to this COVID-19 provider/staff for the individual named below to be vaccinated with COVID-19 vaccine.
- I hereby acknowledge that I have been given the opportunity to review a copy of the Provider's Privacy Notice.
- I understand that information about this COVID-19 vaccination will be included in (WebIZ) Arkansas Immunization Information System.

To My Insurance Carrier(s):

- I authorize the release of any medical information necessary to process my insurance claim(s).
- I authorize and request payment of medical benefits directly to this COVID-19 Provider.
- I agree that the authorization will cover all medical services rendered until I revoke the authorization.
- I agree that the photocopy of this form may be used instead of the original.

My signature below indicates I have read, understand, and agree to RELEASE AND ASSIGNMENT of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA). I also agree to waiting 15 minutes after receiving my COVID-19 Vaccine to be observed for any immediate allergic reactions.

Signature of Patient (or guardian): _____ **Date:** _____

FOR PHARMACY USE ONLY

Vaccine Administered: ☐ Pfizer COVID-19 Vaccine **Dose:** 0.3mL **Route of Administration:** Intramuscular

☐ Moderna COVID-19 Vaccine **Dose:** 0.5mL **Route of Administration:** Intramuscular

Lot Number: _____ **Expiration Date:** _____ **Site Code:** LD / RD

Signature of Vaccine Administrator: _____ **Title:** _____ **Date Given:** _____