FOOD CITY PHARMACY COVID-19 IMMUNIZATION CONSENT FORM

NAME: _____ DOB: _____ AGE: _____ WEIGHT: _____ F ☐ M ☐ PHONE: (_____) _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____
CURRENT MEDICAL CONDITION(S): _____ CURRENT MEDICATION(S): _____
ALLERGIES & REACTIONS (drug, vaccine, food, pet, venom, environmental, etc.): _____
PRIMARY CARE PROVIDER (PCP)/PHYSICIAN NAME: _____ PCP/PHYSICIAN CONTACT #: (____) _____
EMERGENCY CONTACT NAME & RELATION: _____ EMERGENCY CONTACT #: (____) _____

Please read & complete the questionnaire. If you do not understand a question(s), please ask the pharmacist.

1. Have you ever had a serious or bad reaction after receiving a vaccination or to any previous vaccine(s)?	☐ YES	☐ NO
2. Are you sick today?	☐ YES	☐ NO
3. Have you ever had an allergic reaction to chicken eggs, egg products, chicken feathers, thimerosal, mercury, neomycin, gelatin, yeast, latex, any injectable medication, any vaccine, or any vaccine component [including polyethylene glycol (PEG) or polysorbate]? If yes, please list: _____	☐ YES	☐ NO
4. Have you received any blood, blood products, antibody products, or immune globulin in the past year?	☐ YES	☐ NO
5. Are you pregnant, breastfeeding, or are you planning to become pregnant in the next month?	☐ YES	☐ NO
6. Do you, any person who lives with you, or any person you take care of have a weakened immune system/any known immunosuppression state or disease? (due to cancer, HIV/AIDS, hepatitis, chronic steroid use, etc.)	☐ YES	☐ NO
7. Have you ever suffered from/been diagnosed with Guillain-Barré syndrome, epilepsy, seizure disorder, or a nervous system problem in the past or other neurological disorder related to a vaccine?	☐ YES	☐ NO
8. Do you have any of the following chronic health conditions: heart disease, lung disease, liver disease, kidney disease, and/or diabetes? Please specify: _____	☐ YES	☐ NO
9. Have you taken any antiviral treatment within the past 24-48 hours?	☐ YES	☐ NO
10. Do you take anticoagulation medication (warfarin or other blood thinner) or have a bleeding disorder?	☐ YES	☐ NO
11. Do you have a history of or a risk factor for a blood clotting disorder?	☐ YES	☐ NO
12. Do you have dermal fillers?	☐ YES	☐ NO
13. Have you received any vaccinations in the past 4 weeks? If so, please list: _____	☐ YES	☐ NO
14. Have you had a pneumococcal vaccine within the past 5 years?	☐ YES	☐ NO
15. Have you ever had the shingles or meningitis vaccine?	☐ YES	☐ NO
16. When did you have your last influenza vaccine? _____		
17. Have you had a physical examination by a physician, physician assistant, or advanced practice registered nurse within the year preceding the date for vaccine administration?	☐ YES	☐ NO
18. When did you have your last physical examination? _____		
19. Did you bring your immunization record with you?	☐ YES	☐ NO

Food City Statement: I certify that I am: (i) the patient and at least 18 years old, or (ii) the parent or legal guardian of the minor patient 12-17 years old with a prescription, or (iii) the parent or legal guardian of the minor patient 14-17 years old requesting immunization with the influenza vaccine, or (iv) the parent or legal guardian of the minor patient requesting immunization with the COVID-19 vaccine, or (v) the legal guardian of the patient. I give my consent to the certified immunizer at Food City Pharmacy to administer the vaccine(s) listed below. I understand that it is not possible to predict all potential side effects or complications associated with vaccines. I have had the opportunity to ask questions that were answered to my satisfaction. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Food City Pharmacy, its employees, officers, agents, and affiliates from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccines by Food City Pharmacy employees or student representatives.

****Immunization information is protected health information as required by HIPAA.** ****Initials** _____

I have received and read or had explained to me the Food City Statement and Vaccine Information Statement(s)/Emergency Use Authorization fact sheet on the vaccine(s) to be given. I understand the benefits and risks. I request that the vaccine(s) be given to me or the person named above for whom I am authorized to make this request. I acknowledge that my vaccination record will be reported to the state immunization information system (vaccine registry). I acknowledge that adverse event(s) subsequent to the administration of the vaccine will be reported to the appropriate authority. I acknowledge that the pharmacist/nurse has provided me with written information developed by the Department of Public Health on the importance of having and periodically seeing a primary care physician (for the state of Georgia). I acknowledge that the pharmacist/nurse has provided me with a personal immunization card or updated my existing card. I authorize the pharmacist/nurse to notify my primary care provider/physician of the vaccination(s) administered. I agree to wait under observation by a Food City pharmacist or immunizer for not less than 15 minutes immediately subsequent to the administration of the vaccine(s).

*****SIGNATURE:*** _____ *****DATE:*** _____

FOR INTERNAL USE ONLY ☐ ***Immunizer counseled patient to remain near location for 15-30 minutes*- MUST CHECK BOX**

Vaccine: _____ Dose: _____	Vaccine: _____ Dose: _____	*Pharmacist/Nurse Name:* _____
Manufacturer: _____	Manufacturer: _____	*Pharmacist/Nurse Lic #:* _____
NDC: _____	NDC: _____	*Pharmacy Address*: _____
Vaccine Lot #: _____ Exp: _____	Vaccine Lot #: _____ Exp: _____	_____
Diluent Lot #: _____ Exp: _____	Diluent Lot #: _____ Exp: _____	_____
Series #: _____ of _____	Series #: _____ of _____	*Pharmacy Telephone #:* (_____) _____
Inj. Site/Route: L R _____	Inj. Site/Route: L R _____	*Notes:* _____
Administered by: _____	Administered by: _____	_____
Date Given: ___/___/___ Time: _____AM/PM	Date Given: ___/___/___ Time: _____AM/PM	_____
VIS/EUA Given: __/__/__ Version: __/__/__	VIS/EUA Given: __/__/__ Version: __/__/__	_____

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Name: _____ **DOB:** _____ **Temperature:** _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black or African American ☐ White ☐ Other Race

Ethnicity: ☐ Hispanic ☐ Not Hispanic or Latino ☐ Unknown

Insurance Information (Select and Complete Below): ☐ **Commercial/Private** ☐ **Medicare** ☐ **Medicaid** ☐ **No Insurance**

Commercial Insurance:
Patient Primary Card Holder? Y/N Provider: _____ ID #: _____

Group ID: _____ BIN: _____ PCN: _____

Medicare (COVID-19 vaccine will be billed under Medicare Part B):
I ask that payment of authorized Medicare benefits be made on my behalf to Food City Pharmacy for services provided to me by Food City Pharmacy. I am authorizing any holder of medical or other information about myself to be released to the Health Care Financing Administration (HCFA) and its agents, including any information needed to determine any and all benefits for related services.
***Signature:** _____ ***Date:** _____ **Medicare ID:** _____

Medicaid:
Provider: _____ ID #: _____

Group ID: _____ BIN: _____ PCN: _____

No Insurance:
SSN* (or Driver's License): _____

**A SSN and state of residence, or state identification / driver's license is needed to verify patient eligibility. If a SSN and state of residence, or state identification / driver's license is not submitted, you will need to attest that you attempted to capture this information before submitting a claim and the patient did not have this information at the time of service, or that you did not have direct contact with the patient and thus did not have an opportunity to attempt to capture this information. Claims submitted without a SSN and state of residence, or state identification / driver's license may take longer to verify for patient eligibility.*

☐ **By checking this box, I acknowledge I do not have commercial/private insurance, Medicare, Medicaid, or any other form of health care coverage. I acknowledge that the cost of services rendered for the COVID-19 vaccination will be covered by the HRSA COVID-19 Uninsured Program.**

Have you ever received a COVID-19 vaccine? **Y/N** **Date Received:** _____ **Vaccine Product:** _____

Did you have any type of reaction to a COVID-19 vaccine? **Y/N**
If YES, explain reaction: _____

Have you ever tested positive for COVID-19 or has a doctor ever told you that you had COVID-19? **Y/N**
If YES, when: _____

Are you currently being monitored for COVID-19? **Y/N**

In the past two weeks, have you been in contact with any individual who tested positive for COVID-19? **Y/N**

Have you received passive antibody therapy (monoclonal antibodies, convalescent plasma) as a treatment for COVID-19 within the last ninety (90) days? **Y/N**

Select any new symptoms you are experiencing today or have experienced recently:

☐ fever	☐ muscle pain or body aches	☐ other flu-like symptoms
☐ headache	☐ shortness of breath	☐ loss of taste or smell
☐ cough	☐ difficulty breathing	☐ nausea or vomiting
☐ chills	☐ sore throat	☐ diarrhea

***SIGNATURE:** _____ ***DATE:** _____