COVID-19 VACCINE SCREENING AND CONSENT FORM PFIZER COVID-19 Vaccine

Wellness Family Pharmacy

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Phone: (610)234-2922

Name: First:________________________________ Last: ________________________________Middle initial:____ DOB:___/___/____

Address: ____City__________________________State: ________ Zip:_____________

Phone: Cell_____________________________________Home____________________________________

Email: ____

Sex	**Race**	**Ethnicity**
☐ Male ☐ Female	☐ American Indian or Alaska Native ☐ Native Hawaiian or other ☐ Other Asian ☐ Unknown ☐ Asian ☐ Pacific Islander ☐ Other Nonwhite ☐ Black or African American ☐ White ☐ Other Pacific Islander	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Insurance Company Name: ___________________________________ Insurance Company Phone Number: _________________________________

RX Bin #:______________________ RX PCN:____________________ RX Group:_______________________ RX ID:___________________________

Medicare B Card #: ____________________________ ☐ **I don't have insurance**

Is this the patient's first, second or booster dose of the COVID-19 vaccination? ☐ 1st Dose ☐ 2nd Dose 3rd Dose 4th Dose

SCREENING QUESTIONS

Please check YES or No for each question.	**Yes**	**No**
1. Are you sick today?		
2. Do you have a long term health problem with heart disease, kidney disease, metabolic disorder (e.g. diabetes), anemia or other blood disorders?		
3. Do you have long term health problem with lung disease or asthma? Do you smoke?		
4. Do you have allergies or reactions to any medications, foods (i.e. eggs), latex or any vaccine component The Pfizer-BioNTech COVID-19 Vaccine includes the following ingredients: mRNA, lipids ((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene glycol)-2000]-N,Nditetradecylacetamide, 1,2-Distearoyl-sn-glycero-3- phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose.		
5. Have you ever had a serious reaction after receiving a vaccination?		
6. Do you have a neurological disorder such as seizures or other disorders that affected the brain or have had a disorder that resulted from a vaccine (e.g. Guillain-Barre Syndrome)?		
7. Are you immunocompromised or on a medication (e.g. prednisone) that affects your immune system?		
8. For females: are you pregnant or could you become pregnant in the next three months?		
9. For females: are you currently breastfeeding?		
10. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		

SECTION 2: COVID-19 SCREENING QUESTIONS

Please check YES or No for each question.	Yes	No
11. Have you tested positive for and/or been diagnosed with COVID-19 infection within the last 10 days?		
12. Have you had any COVID-19 Antibody therapy within the last 90 days (e.g. Regeneron, Bamlanivimab, COVID Convalescent Plasma, etc?)		
13. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive:______________________________________		
14. Did you bring your Immunization Record Card with you?		

- I certify that I am authorized to consent for vaccination for the patient named above and confirm that the patient is at least 12 years of age.

- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

- I acknowledge that I have been advised to **remain near the vaccination location for approximately 15 minutes** (or more in specific cases) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.

- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Wellness Family Pharmacy and their staffs, agents, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.

- I acknowledge that: (a) I understand the purposes/benefits of Pennsylvania immunization registry and (b) Wellness Family Pharmacy will include my personal immunization information in PA SIIS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.

- I further authorize Wellness Family Pharmacy to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to Wellness Family Pharmacy with respect to the above requested items and services.

- I acknowledge receipt of the Notice of Privacy Rights.

Signature of Patient or Authorized Representative _______________________________________**Date**: ____/____/___

Print Name of Representative and Relationship to Person Receiving Vaccine: ___________________________________

For Vaccinator Only:

Vaccine Name	Manufacture	Lot	Expiration Date	Dosage	Site	Date of EUA Fact Sheet
Pfizer Covid -19 Vaccine	Pfizer			**0.3 ml**	**RD LD**	

Vaccinator Print Name: ______________________________ **Signature:** _______________________________ **Date:** ________