VACCINE INFORMED CONSENT FORM

BLUE DOVE PHARMACY

PATIENT INFORMATION

Full Name (First MI Last): _____ Date of Birth: _____ Age: _____

Email: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Gender: ☐ Male ☐ Female Race: _____ Ethnicity: _____

Primary Care Doctor: _____ City/State: _____

Have you received a COVID-19 vaccine? ☐ Yes ☐ No

If yes, which vaccine did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen ☐ Other _____

If no, which vaccine would you prefer to receive? ☐ Pfizer ☐ Moderna ☐ Janssen

For those who received at least one dose of Pfizer or Moderna only:

Which dose of COVID-19 vaccine will this be? ☐ Second ☐ Third / Booster *(please see reverse side for qualifications)*

Date of First Dose: _____ Date of Second Dose: _____

For those who received Janssen / Johnson & Johnson only:

Which dose of COVID-19 vaccine will this be? ☐ Second / Booster

Date of First Dose: _____ Which booster vaccine would you prefer? ☐ Pfizer ☐ Moderna ☐ Janssen

SCREENING QUESTIONS: Pleast select the correct option below.

	YES	NO	Don't Know or N/A
Do you feel sick today?			
In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?			
If yes to the previous question, did you receive any medications, plasma or other treatment?			
In the past two weeks, have you had a known exposure with anyone who tested positive for COVID-19?			
Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?			
Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?			
Do you have an allergy to any food, medication or vaccine? If so, please specify allergy: _____			
Have you ever had a serious reaction or fainted after receiving any vaccination?			
Do you carry an EpiPen?			
Do you have a bleeding disorder or take a blood thinner?			
Have you ever had a seizure, brain disorder, or Guillain-Barre Syndrome?			
Do you have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies?			
Do you have a history of myocarditis or pericarditis?			
Do you have a history of heparin-induced thrombocytopenia (HIT)?			
FOR WOMEN: Are you currently pregnant or breastfeeding?			

I understand the benefits and risks of the vaccination(s) as described in the Vaccine Information Sheet (VIS) or Emergency Use Authorization (EUA), a copy of which I was provided with this Consent and Release. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent and Release.

Signature of Patient to Receive Vaccine & VIS/EUA (or Signature of Power of Attorney or Legal Guardian) _____

I have received a copy of the notice of Privacy Practices. I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the pharmacy and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Signature of Acknowledgement of Notice of Privacy Practices _____

Insurance Information & Authorization:

☐ I hereby authorize the pharmacy to bill my insurance on my behalf for the COVID-19 vaccine administration fee and/or a different vaccine and receive payment.

Member #: _____ Rx Group: _____

BIN #: _____ PCN #: _____

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COVID-19 VACCINATION ATTESTATION FOR ADDITIONAL DOSE

This attestation form is used to verify your eligibility to receive an additional dose of mRNA COVID-19 vaccine.

For those who received Pfizer or Moderna two-dose primary series ONLY:

Please mark any of the following conditions that you meet:

- ☐ I have been receiving active cancer treatment for tumors or cancers of the blood
- ☐ I have received an organ transplant and am taking medicine to suppress the immune system
- ☐ I have received a stem cell transplant within the last 2 years or am taking medicine to suppress the immune system
- ☐ I have moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
- ☐ I have advanced or untreated HIV infection
- ☐ I have active treatment with high-dose corticosteroids or other drugs that may suppress my immune response

If yes to any of the above, a third dose is recommended at least 28 days after the date of the second dose. You will receive the vaccine from the same manufacturer as you received for your primary series.

If none of the above apply, please mark any of the following conditions that you meet:

- ☐ I am an adult age 65 or older or a resident of a long-term care facility
- ☐ I am an adult age 50 to 64 with an underlying medical condition
- ☐ I am an adult age 18 to 49 with an underlying medical condition, and I feel I need an additional dose based on my individual benefits and risks.
- ☐ I am an adult age 18 to 64 at an increased risk for COVID-19 exposure and transmission because of occupational or institutional setting.

If yes to any of the above, a booster dose is recommended at least 6 months after the date of the second dose. You may choose which manufacturer's vaccine you would like to receive for the booster dose.

Which booster vaccine would you prefer to receive? ☐ Pfizer ☐ Moderna ☐ Janssen

I attest that I meet one or more of the criteria listed above.

Signature of patient, power of attorney, or legal guardian: _____

If not patient, relationship to patient: _____

Printed name: _____ Date: _____

---------- **PHARMACY USE ONLY** ----------

VACCINE	BRAND/MFG	DOSAGE	ROUTE	SITE	EUA /VIS	LOT	EXP. DATE	STATUS
COVID-19	☐ Moderna	☐ 0.5mL ☐ 0.25mL	IM	R or L Arm	8/27/21			☐ Billed
COVID-19	☐ Pfizer	☐ 0.2mL ☐ 0.3mL	IM	R or L Arm	9/22/21			
COVID-19	☐ J&J	0.5mL	IM	R or L Arm	8/27/21			☐ Iris
Influenza ☐ Quad ☐ High Dose ☐ Fluad ☐ Mist		☐ 0.7mL ☐ 0.5mL ☐ 0.25mL ☐ 0.2mL	☐ IM ☐ SQ	R or L Arm Thigh Intranasal				☐ Fax PCP
Other _____								☐ Scanned

Signature of Pharmacist who administered_____**Date Administered:**_____