Vaccine Consent & Assessment: COVID19

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	AGE	GENDER
			/ /		M F

ADDRESS	CITY	STATE	ZIP	PHONE

COMMERCIAL INSURANCE NAME/ID # -- Medicare A/B Number -- No insurance = Social Security Number	QUALIFICATION

COVID19

COVID-19 Vaccines Contraindications *The purpose of these questions is for vaccine administration tier scheduling and to assess for vaccine exclusions based on declared health conditions. Please read the following questions carefully and indicate your answers in the field provided.* ***Moderna COVID-19 Vaccine*** *- The manufacturer advises against administration of Moderna COVID-19 Vaccine to individuals with known history of a severe allergic reaction (e.g. anaphylaxis) to any component of the Moderna COVID-19 Vaccine. The Moderna COVID-19 Vaccine contains the following ingredients: messenger ribonucleic acid (mRNA), lipids (SM-102, polyethylene glycol [PEG] 200- dimyristoyl glycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose.* ***Pfizer-BioNTech COVID-19 Vaccine*** *- The manufacturer advises against administration of Pfizer-BioNTech COVID-19 Vaccine to individuals with known history of severe allergic reaction (e.g. anaphylaxis) to any component of the Pfizer-BioNTech COVID-19 Vaccine. The ingredients are mRNA, lipids ((4-hydroxybutyl)azanediyl)bis(hexane-6 ,1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene glycol)-2000]-N, N-ditetradecylacetamide, 1, 2-distearoyl-sn-glycero-3-phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose.*	YES	NO
1. Do you have a history of an allergic reaction to any of the ingredients listed above?		
2. Do you have a history of severe allergic reactions, such as an immediate-onset anaphylaxis to vaccine components (e.g. diphtheria toxoid, gelatin, neomycin, polymyxin, yeast, thimerosal, aluminum etc.)? *Please list:* _____		
3. Do you have a history of severe allergic reactions, such as an immediate-onset anaphylaxis to medications or food (e.g. egg)? *Please list:* _____		
4. Do you have a fever or illness today?		
5. Are you pregnant?		
6. Have you received any vaccine (pneumococcal, flu) within the last 14 days?		
7. Have you tested positive for COVID-19 in the last 60-90 days?		
8. What race/ethnicity do you identify with? (please circle below) *required per CDC guidelines* White Asian Native American/Alaska Native Pacific Islander/Native Hawaiian Black/African American Other Hispanic		

I hereby give my consent to the healthcare provider of this pharmacy, to administer the vaccine(s) indicated above to me or the person named below for whom I am authorized to make this request. I understand the risks and benefits associated with the vaccine(s) being administered and have received, read and/or had explained to me the written information regarding the vaccine(s) I requested and have received a copy of the Vaccine Information Statement (VIS). 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 the pharmacy, Dr. Ronald Ferris, MD, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all liabilities or claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) requested or any medications related to the administration of the vaccine(s). I understand that a copy of the information on this form will be sent to my primary physician (if listed and known) or the pharmacy's protocol doctor. I understand that the information contained on this form may be shared with the State Health Department and Kansas Immunization Registry, and will remain confidential and will not be released except as permitted or required by law. If eligible, I authorize this pharmacy to submit a claim for reimbursement on my behalf to Medicare or any other contracted third party payer. **If the claim is denied, I understand that I will be responsible for payment.** I am authorizing any holder of medical or other information about myself to be released to Centers for Medicare and Medicaid Services (CMS) and its agents, including any information needed to determine any and all benefits for related services. The pharmacy protects the confidentiality of your health information. I have received the Notice of Privacy Practices. **Furthermore, I agree to remain near the vaccination location for approximately 15-20 minutes after administration of the vaccine(s) for observation.**

X

SIGNATURE OF PERSON TO RECEIVE THE VACCINE OR PERSON AUTHORIZED TO MAKE THE REQUEST (PARENT OR GUARDIAN) **DATE**

---------- **For Pharmacy Use Only** ----------

DOSE #:	VACCINE NAME:	LOT NO.	Deltoid Site:
1 or 2			LA RA
Immunizer/Title		**Supervising RPh**	**Date**