Immunization & Consent Form: COVID-19

Patient Information

Last Name: _____ First Name: _____ MI: __

Mother's Maiden Last: _____ Mother's First Name: _____

Date of Birth: _____ Gender: Email: _____

Social Security: _____ Cell Phone: _____

Address: _____

Insurance

☐ MEDICARE B ☐ MEDICAID

☐ MEDICARE D ☐ COMMERCIAL: _____

Group #: _____ Bin #: _____

ID: _____ PCN: _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it

		YES	NO	Don't Know
1	Are you feeling sick today?			
2	Have you ever received a dose of COVID-19 vaccine? If yes, which product did you receive? ☐ Pfizer ☐ Moderna ☐ Another product: _____			
3	Have you ever had an allergic reaction to the following ingredients: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
	• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
	• Polysorbate			
	• A previous dose of COVID-19 vaccine			
4	Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.			
6	Have you received any vaccine in the last 14 days?			
7	Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10	Do you have a bleeding disorder or are you taking a blood thinner?			
11	Are you pregnant or breastfeeding?			

Patient Consent

This pharmacy may keep this record in my profile, recording what vaccine was given and when it was administered, its manufacturer, the lot and expiration, and the immunizer who administered the vaccine administered at 136 N Main St in Thiensville, Wisconsin. Your signature signs off on the following: "I have read or have had explained to me the information provided regarding the vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits as well as the risks of this vaccine, and give permission to have the vaccine administered to me."

I understand it is recommended that I remain on-site for at least 15 minutes after receiving the Pfizer vaccine and that, depending on the recommendations of medical professionals, I may be asked to remain on-site longer for monitoring.

_____ _____

Signature Patient/Legal Guardian Date

_____

Printed Name

PHARMACY USE ONLY:

Pharmacist Signature: _____ Administration Date: _____

Manufacturer: ☐ Pfizer ☐ Moderna Lot #: _____ Exp Date: _____

DL (R or L): _____ ☐ Dose #1 ☐ Dose #2