**Pharmacy Pre-screening and Consent For COVID-19 Vaccine 2.0**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_**

For vaccine recipients:

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 questions, 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 pharmacist to explain it.

|  |  |  |  |
| --- | --- | --- | --- |
| Question | Yes | No | Don’t Know |
| 1. Are you feeling sick today?
 |  |  |  |
| 1. Have you ever received a dose of COVID-19 vaccine?
 |  |  |  |
| * If yes, which vaccine did you receive?

 \_\_\_\_ Pfizer \_\_\_\_Moderna \_\_\_\_\_\_\_\_ Janssen \_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Have you ever had an allergic reaction to:

(This would include a severe allergic reaction [anaphylaxis] that required treatment with epinephrine or an Epi-Pen 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, which is found in some vaccines, film coated tablets, and IV steroids
 |  |  |  |
| * A previous dosage of COVID-19 vaccine
 |  |  |  |
| * A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but is not known which component elicited the immediate reaction.
 |  |  |  |
| 1. Have you ever had an allergic reaction to another vaccine (other than COVID-19) or an injectable medication?

 (This would include a severe allergic reaction [anaphylaxis] that required treatment with epinephrine or an Epi-Pen 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.) |  |  |  |
| 1. Have you ever had an allergic reaction (anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pets, venom, environmental, or oral medication allergies?
 |  |  |  |
| 1. Have you received any vaccination in the last 14 days?
 |  |  |  |
| 1. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?
 |  |  |  |
| 1. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19?
 |  |  |  |
| 1. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?
 |  |  |  |
| 1. Do you have a bleeding disorder, have a problem with your platelets, or are you taking a blood thinner?
 |  |  |  |
| 1. Are you pregnant or breastfeeding?
 |  |  |  |
| 1. Do you have dermal fillers?
 |  |  |  |

**Pre-screening and Consent For COVID-19 Vaccine, Cont.**

**Please place your initials next to the statements below to acknowledge your understanding**

\_\_\_\_\_\_ I feel at my baseline health status today.

\_\_\_\_\_\_ I have had the opportunity to read and ask questions about the COVID-19 VIS/EUA Fact Sheet. My questions were answered to my satisfaction.

\_\_\_\_\_\_ I believe I understand the benefits and risks of the vaccine and asked that the vaccine will be given to me or the person named above as I am authorized to make this request.

\_\_\_\_\_\_ I understand this is a 2-dose series (staff to circle dose return date: 21 or 28 days apart) and it is not fully effective unless I receive both doses within the recommended time frame.

\_\_\_\_\_\_ If there is a possibility of pregnancy I have discussed with this with my physician and we agree to receive vaccine although no studies have been done on pregnant women with this vaccine.

\_\_\_\_\_\_ I understand, even though I am receiving this vaccine, I can still acquire and spread COVID -19 even without symptoms and I need to follow CDC guidelines on social distancing, wearing a face covering, hand hygiene and disinfection measures.

\_\_\_\_\_\_ I understand getting vaccinated does not guarantee immunity to COVID-19.

\_\_\_\_\_\_ I received my COVID-19 Vaccine Record Card with information on approximate return date for the second vaccination, product name and lot number I also received V-safe handout.

**1st Dose Patient Signature: Date:**

1st Dose Staff Signature: Co-signer:

Vaccine Manufacturer: Lot #: Injection Site:

Observation time: 15 min. or 30 min. Release Time: Immediate Side Effects:

 SOB Rapid Heart Rate Low Blood Pressure Lightheaded Angioedema Other:

**Before receiving my 2nd Vaccination I have reviewed the above information and have reported any significant adverse reactions to the first COVID-19 Vaccination.**

If you experienced a reaction, please describe:

Were you referred to an allergist if your reaction to the first vaccine occurred within 24 hours?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2nd Dose Patient Signature: Date:**

2nd Dose Staff Signature: Co-signer:

\*By signing for second dose I verify that the above section regarding a significant adverse reaction has been reviewed and reported before a second vaccine is administration if indicated.

Vaccine Manufacturer: Lot #: Injection Site:

Observation time: 15 min. or 30 min. Release Time: Immediate Side Effects:

 SOB Rapid Heart Rate Low Blood Pressure Lightheaded Angioedema Other: