Family Health Care

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Pharmacy Pre-screening and Consent For COVID-19 Vaccine 3.0

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?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine did you receive? ____ Pfizer ____Moderna ________ Janssen ______ Other: __________________			
3. 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.			
4. 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.)			
5. Check all that apply to you: ☐ Am a female between the ages of 18 and 49 years old ☐ Had a severe allergic to something other than a vaccine or injectable therapy such as food, pets, venom, environmental, or oral medication allergies ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection ☐ Have a weakened immune system (i.e., HIV infection, cancer) ☐ Take immunosuppressive drugs or therapies ☐ Have a bleeding disorder			

Pharmacy Insurance Coverage: BIN#:____________ PCN:____________ ID#:____________ Group:____________

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

☐ Take a blood thinner

☐ Have a history of heparin-induced thrombocytopenia (HIT)

☐ Am currently pregnant or breastfeeding

☐ Have received dermal fillers

Reviewed by: ____ Date: ____________________
Pharmacist signature

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: ____________________