COVID-19 VACCINE SCREENING & CONSENT FORM

☐ PA-SiiS ☐ Pioneer

GENERAL PATIENT INFORMATION (PLEASE PRINT- MUST BE LEGIBLE)

Name: First: _____ Last: _____ Middle Initial:_____

DOB: ____/____/_____ Age: _____ Phone: _____

Address (REQUIRED):_____ City: _____ State: ____ Zip: _____

Sex
- ☐ **Male**
- ☐ **Female**

Age Group
- ☐ **50+**
- ☐ **18-49**
- ☐ **12-17 (PFIZER ONLY)**
- ☐ **5-11 (PFIZER ONLY)**

Race
- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Pacific Islander
- ☐ Unknown

***What dose is this COVID-19 vaccination?**
- ☐ **First Dose**
- ☐ **Second Dose**
- ☐ **First Booster (3rd Dose)**
  **** APPROVED FOR 12+**
- ☐ **Second Booster (4th Dose)**
  **** APPROVED FOR 50+**

***Previous Dose(s)**
- ☐ ***Pfizer***
- ☐ ***Moderna***
- ☐ ***Johnson & Johnson (J &J)***

INSURANCE INFORMATION ******PLEASE ATTACH COPY OF YOUR INSURANCE & Driver's License******

(PLEASE DO NOT GIVE US YOUR MEDICAL CARD, NEED A PRESCRIPTION CARD THAT HAS A BIN NUMBER)

If over 65, Medicare ID #: _____ *OR* ***Social Security Number (SSN):*** _____

****IF NO INSURANCE: Driver's License Number: _____ OR LAST 4 DIGITS SSN: _____**

WOULD YOU LIKE FREE COVID-19 AT-HOME TESTS? (circle one): YES NO

SUBJECT TO INSURANCE LIMITS (MOST INSURANCES ARE ALLOWING UP TO 8 TESTS PER 30 DAYS, INCLUDING MEDICARE PART B)

COVID-19 VACCINE SCREENING QUESTIONS

Please check **YES** or **NO** for each of the following questions	**YES**	**NO**
1. Are you feeling sick today?		
2. Have you ever had an ALLERGIC REACTION to any of the folowing: (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 or ***previous dose of a COVID-19 vaccine***, including polyethylene glycol (PEG) or polysorbate, which is found in some medications, such as laxatives and colonoscopy preps. • ***Another vaccine*** (other than COVID-19 vaccine) or an injectable medication? Please explain: _____ • Something other than a vaccine or injectable medication? Including food, pets and medications. Please explain: _____		
3. Have you ever fainted or felt dizzy after receiving a vaccine? (Please verbally notify vaccinator)		
4. Have you received any vaccines in the last 14 days? If yes, what vaccine: _____		
5. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? When was your positive test _____		
6. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?		
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs (e.g. prednisone) or therapies?		
8. Do you have a bleeding disorder or are you taking a blood thinner?		
9. FOR WOMEN ONLY: Are you pregnant or breastfeeding?		

- ✔ I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 12 years of age (Pfizer only); or (c) authorized to consent for vaccination for the patient named above. Furthermore, I hereby give my consent to Rann Pharmacy or its associates to administer the COVID-19 vaccine.
- ✔ MODERNA: I understand that this product has not been approved or licensed by the FDA, but has been authorized for emergency use by the FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals ***18 years or age and older***; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization is revoked sooner.
- ✔ I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine that I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- ✔ I acknowledge that I have been advised to remain near the vaccination location for **approximately 15 minutes** (or more, in specific cases) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- ✔ On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Rann Pharmacy and their staffs, agents, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.
- ✔ I acknowledge that: (a) I understand the purposes/benefits of Pennsylvania's immunization registry (PA-SIIS) and (b) Rann Pharmacy will include my personal immunization information in the PA-SIIS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- ✔ I further authorize the Rann Pharmacy to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to the Rann Pharmacy with respect to the above requested items and services.
- ✔ I acknowledge the receipt of the Notice of Privacy Rights.

****Patient/Authorized Representative (ex. parent if child is <18 or Power of Attorney)**:**

_____ _____ **Date: ___/___/_____**

(Printed Name) (Signature)

FOR VACCINATOR ONLY: PATIENT'S TEMPERATURE: _____

Vaccine Name	*Manufacturer*	*LOT*	*EXP. DATE*	*Dosage*	*Site*	*Date of EUA Fact Sheet*
					RIGHT Deltoid LEFT Deltoid	

Vaccinator Name: _____ Signature: _____ Date: ___/___/____

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