

COVID-19 VACCINE SCREENING & CONSENT FORM (AGES 12+)

PA-SiS Pioneer

GENERAL PATIENT INFORMATION (PLEASE PRINT- MUST BE LEGIBLE)

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

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

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

Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Unknown	*What dose is this COVID-19 vaccination? <input type="checkbox"/> First Dose (Primary) <input type="checkbox"/> Second Dose (Primary) <input type="checkbox"/> First Booster (3rd Dose) <input type="checkbox"/> Second Booster (4th Dose) <input type="checkbox"/> Third Booster (5th Dose)	*Previous Dose(s) <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Johnson & Johnson (J&J) Bivalent Boosters approved for ages 12+ (Pfizer) and 18+ (Moderna) if at least 2 months since last vaccine
Age Group <input type="checkbox"/> 50+ <input type="checkbox"/> 18-49 <input type="checkbox"/> 12-17 <input type="checkbox"/> 5-11 (PFIZER ONLY)			

INSURANCE INFORMATION ****DRIVER'S LICENSE & INSURANCE CARD IF 1ST VACCINE HERE****

(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 following: (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.) <ul style="list-style-type: none"> A component or <i>previous dose of a COVID-19 vaccine</i>, including polyethylene glycol (PEG) or polysorbate, which is found in some medications, such as laxatives and colonoscopy preps. <i>Another vaccine</i> (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 tested positive for COVID-19 within the last 4 months? If yes, when: _____		
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?		
WOULD YOU LIKE A FLU SHOT TODAY?		
If yes, do you have a moderate to severe allergy to eggs? If yes, please explain: _____		

- ✓ 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; 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 & BIVALENT PFIZER VACCINE:** 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) and 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: _____

<i>Vaccine Name</i>	<i>Manufacturer</i>	<i>LOT</i>	<i>EXP. DATE</i>	<i>Dosage</i>	<i>Site</i>	<i>Date of EUA Fact Sheet</i>
					RIGHT Deltoid LEFT Deltoid	
					RIGHT Deltoid LEFT Deltoid	

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

