

COVID-19 Vaccine Consent and Administration Record

PATIENT INFORMATION				
Name:	Date of Birth:/Gender:	:Phone:		
	City, State:		Zip:	
Ethnicity: ☐ Hispanic or Latino ☐ Not Hi	spanic or Latino 🛘 Unknown			
Race: American Indian or Alaska Native	\square Asian \square Native Hawaiian or Other Pacific	Islander 🗆 Black	or African	-American
Primary Care Provider (PCP) Name: If someone else manages healthcare decisions of	rom this visit to your primary care provider using the conta	nformation:		•
INSURANCE INFORMATION – Please				
▶ Prescription Insurance □ Chec	ck box if patient is the primary card holder			
Pharmacy Insurance Provider:	Member ID #:	Rx Group #:		
RX BIN: RX PCN:				
Medicare Beneficiaries (the COVID	Vaccine will be billed at Part B through your Medica	are provider)		
Is the patient age 65 or older or is the patie	ent Medicare Eligible? ☐ Yes ☐ No	Medicare Number	(MBI):	
Medical Insurance □ Check bo	ox if patient is the primary card holder			
Medical Insurance Provider:	Member ID #:	Payer ID:		
I do not have medical insurance, Medicar that I must answer this question truthfull	g statement and check the box for acknowledger re, Medicaid, or any government-funded health ben y in order to have the cost of my vaccination covere lose any active insurance I have, I may be charged in	efit plan or any comed by the federal CO	VID-19 Unin	
SCREENING QUESTIONS FOR COVID	0-19 VACCINE			
The following questions will help us determine whi "yes" to any question, it does not necessarily mear additional questions must be asked. If a question is		Yes	No	Don't Know
1. Are you sick today?				
EpiPen or that caused you to go to the hospital	to: e.g., anaphylaxis] that required treatment with epinephrin I. It would also include an allergic reaction that occurred w ry distress, including wheezing. If Yes, the vaccine is contra	vithin 4		
	Ovaccine, including polyethylene glycol (PEG), whuch as laxatives and preparations for colonoscopy			
Polysorbate				
A previous dose of COVID-19 v				
component of COVID-19 vaccine, polyso	ction (e.g., anaphylaxis) to something other than orbate, or any vaccine or injectable medication? (al medication allergies. Yes = Provider to observe patient fo	(This		
injectable medication? (This would include a severe allergic reaction [of EpiPen or that caused you to go to the hospital	to another vaccine (other than COVID-19 vaccine) e.g., anaphylaxis] that required treatment with epinephrin l. It would also include an allergic reaction that occurred w ry distress, including wheezing. Yes= Provider observe pt for	ne or		

5. Do you have a weakened immune system caused by something such as cancer or HIV infection or do you take immunosuppressive drugs or therapies?												
6. Do you have a bleeding disorder or are you taking a blood thinner?												
7.	7. For women: Are you pregnant or is there a chance you could become pregnant during the next month?											
8.	8. Have you received any vaccine in the last 14 days?											
9.	Have you ever had a per COVID-19?	r ever told you that you	had									
10.	In the past 14 days, ha results of a COVID-19 t	are you currently waitin	g on the									
11. Within the past 14 days, have you been in close physical contact have laboratory-confirmed COVID-19?						act with anyone who is l	known to					
12. Within the past 14 days, have you been in close physical contact with anyone who has any symptoms consistent with COVID-19?												
13. Have you experienced any of the following symptoms in the past 48 hours: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea?												
14.	Are you isolating or qu 19 or are worried that	_	-	-		exposed to a person wi	th COVID-					
15.	Have you ever received	d a dose of a	COVID-	19 vaccin	e?							
	If yes, which	vaccine prod	uct did y	you recei	ve?							
		□ Moderna		other pro								
16.	Have you received pas treatment for COVID-1		/ therap	y (monoc	clonal anti	bodies or convalescent	serum) as					
PAT	IENT CONSENT											
Recipients and Caregivers provided for the vaccine(s) to be administered. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and voluntarily assume full responsibility for any reactions that may result. I give my consent to the staff of Hy-Vee Pharmacy to administer the vaccine(s) marked above. I have been advised to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I hereby release Hy-Vee, its officers, employees and agents from any and all liability, whether known or unknown, that in any way arise from this vaccination on behalf of myself, my heirs and personal representatives. PAYMENT AUTHORIZATION. I hereby authorize Hy-Vee Pharmacy to request payment and release all information needed to act on this request. I certify that the information given by me in applying for payment under Medicare or Medicaid is correct. I request that payment of authorized benefits be made on my behalf. DISCLOSURE OF RECORDS. I acknowledge that Hy-Vee Pharmacy may be required to or may voluntarily disclose my health information concerning the vaccine(s) to my primary care physician (if provided), my insurance plan, and/or local, state, or federal registries/health agencies, if applicable. I acknowledge that, depending on my state law, I may object to the disclosure of my vaccination information to the state registry. I understand that my health information will be used and disclosed as set forth in the Hy-Vee Pharmacy Notice of Privacy Practices, which is available online or upon request. By signing below, I certify that I am the patient or the patient's guardian/representative authorized to provide consent on their behalf, and that I have read, understand and agree to all the statements on this form.												
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