COVID-19 Vaccine Consent and Administration Record

PATIENT INFORMATION

Name: _____ **Date of Birth:** ___/___/___ **Gender:** _____ **Phone:** _____

Home Address: _____ **City, State:** _____ **Zip:** _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African-American

☐ White ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other Race

Hy-Vee Pharmacy will send vaccination information from this visit to your primary care provider using the contact information provided below. **(OPTIONAL)**

Primary Care Provider (PCP) Name: _____ **PCP Contact Information:** _____

If someone else manages healthcare decisions on the patient's behalf, please provide the following:

Legal Decision-Maker Name: _____ **Relationship:** _____ **Phone:** _____

INSURANCE INFORMATION – Please fill in all that apply

- **Prescription Insurance** ☐ Check 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 Medicare provider)

Is the patient age 65 or older or is the patient Medicare Eligible? ☐ Yes ☐ No Medicare Number (MBI): _____

- **Medical Insurance** ☐ Check box if patient is the primary card holder

Medical Insurance Provider: _____ **Member ID #:** _____ **Payer ID:** _____

- **Uninsured – COVID-19 VACCINE ONLY** Required: Driver's license or Social security # _____

If you are uninsured, please read the following statement and check the box for acknowledgement:

☐ I do not have medical insurance, Medicare, Medicaid, or any government-funded health benefit plan or any commercial plan. I understand that I must answer this question truthfully in order to have the cost of my vaccination covered by the federal COVID-19 Uninsured Program. I understand that if I fail to disclose any active insurance I have, I may be charged in full for the COVID-19 vaccine.

SCREENING QUESTIONS FOR COVID-19 VACCINE

The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider.

		Yes	No	Don't Know
1.	Are you sick today?	☐	☐	☐
2.	Have you ever had an allergic reaction to: (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. If Yes, the vaccine is contraindicated)			
	• 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	☐	☐	☐
	• A previous dose of COVID-19 vaccine	☐	☐	☐
3.	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? (This would include food, pet, environmental, or oral medication allergies. Yes = Provider to observe patient for 30 min)	☐	☐	☐
4.	Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (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. Yes= Provider observe pt for 30 min)	☐	☐	☐

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. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
8. Have you received any vaccine in the last 14 days?	☐	☐	☐
9. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
10. In the past 14 days, have you tested positive for COVID-19 or are you currently waiting on the results of a COVID-19 test?	☐	☐	☐
11. Within the past 14 days, have you been in close physical contact with anyone who is known to have laboratory-confirmed COVID-19?	☐	☐	☐
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 quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	☐	☐	☐
15. Have you ever received a dose of a COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Another product _____			
16. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐

PATIENT CONSENT

CONSENT FOR VACCINE SERVICES. I have read, or have had read to me, the Vaccine Information Statement (VIS) or Emergency Use Authorization (EUA) Fact Sheet for 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.

_____ _____

Patient or Guardian Signature **Date**

FOR PHARMACY USE ONLY

Vaccine	Admin Date	Dose (mL)	Vaccine			Route (IM/SQ/ NAS)	Site (RA/LA, RT/LT)	VIS or EUA Fact Sheet:	
			Lot #	Exp Date	Manufacturer			Pub Date	Date Given

Administering Immunizer Name & Title: _____ **Administering Immunizer Signature:** _____

Pharmacy Address: _____ **City, State, Zip:** _____ **Store #:** _____

If applicable,
Supervising Pharmacist Name: _____ **Supervising Pharmacist Signature:** _____

Adverse Reaction (attach VAERS form) Notification to Primary Provider: _____ **(date)**