CONLIN'S PHARMACY, INC. COVID-19 VACCINATION DOSE 1 CONSENT

Vaccine Recipient Information *(Indicates Required Fields)

*Name: (Last)	*(First)	(M)	*Date of Birth:	*Gender:
*Address:	*City:	*State:	*Zip:	*County:
*Phone Number:	*Email:	*Ethnicity: ☐ Non Hispanic/Latino ☐ Hispanic/Latino		
*Race: ☐ White ☐ Hispanic/Latino ☐ African American ☐ Alaskan Native ☐ Asian ☐ American Indian ☐ Other				
*Primary Care Provider Name:		*PCP Phone:		

Vaccine Recipient Insurance Information *(Indicates Required Fields)

*Do you have Prescription Insurance? ☐ Yes ☐ No	*Are you the primary cardholder? ☐ Yes ☐ No		
*Prescription Benefit Plan Name:	If no, provide primary cardholder's Date of Birth:		
*Cardholder ID #:	RX Group ID: Located on Insurance Card	BIN: Located on Card	PCN: Located on Card
*Are you age 65 or older or Medicare Eligible? ☐ Yes ☐ No	Medicare Part A/B ID Number:		
Note: Required for all patients age 65 and older, or Medicare Eligible. Refer to your Medicare Red, White, and Blue card.			
*Medical Insurance Provider:	*Cardholder ID #:	Group ID:	
*Are you the primary cardholder? ☐ Yes ☐ No	*If no, provide primary cardholder's Date of Birth:		

Screening Questions (All questions below must be answered).

	YES	NO	Don't Know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 Vaccine? • If you have received a dose of COVID-19 Vaccine before, Date of first Dose: _____ • Vaccine Manufacturer: ☐ Pfizer ☐ Moderna ☐ Other:_____	☐	☐	☐
3. 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.)			
• 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:	☐	☐	☐
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.)	☐	☐	☐
5. 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.) **ALLERGY TYPE:**_____	☐	☐	☐
STOP: *If you answered yes, to any questions 3, 4, or 5, please seek the COVID-19 Vaccine from a medical clinic or hospital setting.*			
6. Have you received any vaccine in the last 14 days?	☐	☐	☐
7. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19? Date of positive test:	☐	☐	☐
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? [Note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]	☐	☐	☐
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
10. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
11. Are you pregnant or breastfeeding?	☐	☐	☐

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Consent (check each box below after reading and signing):

☐	I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet https://www.modernatx.com/covid19vaccine-eua/eua-fact-sheet-recipients.pdf copy of which I was provided with this Consent Form. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent Form.
☐	I understand that at this time, the COVID-19 vaccine requires 2 doses given 21-28 days apart depending on the manufacturer. If this is my first dose of the COVID-19 vaccine, I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the vaccination series.
☐	I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur.
☐	I understand that I will be receiving the vaccination at no cost to me. (My Insurance will be charged a small fee for administration of vaccine).
☐	If insured, *please bring in your prescription and medical insurance cards with you to your vaccine appointment. I authorize the pharmacy to bill my insurance on my behalf for the immunization – understanding I will not incur any costs.
	*If uninsured, you must check the box below to attest that the following information is true and accurate:
☐	*I do not have any insurance, including but not limited to, Medicare, Medicaid, or any other private or government-funded benefit plan.

For uninsured patients, please select at least one of the following that you must bring with you to your appointment.

This is needed in order to have your vaccine administration fee paid for by
The United States Health Resources & Services Administration's COVID-19 Program.

Valid Social Security Number	State Identification Card Number	Current Driver's License

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize Conlin's Pharmacy, Inc. to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid, or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS: I understand that Conlin's Pharmacy, Inc. may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at Conlin's Pharmacy, Inc., my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that Conlin's Pharmacy, Inc. will use and disclose my health information as set forth in the Notice of Privacy Practices (copy is available in-store, online or by requesting a paper copy from the pharmacy). I authorize Conlin's Pharmacy, Inc. to share vaccination data with MIIS Registry.

X	**Date:**

***Signature of patient to receive vaccine & EUA/VIS** **(or parent, guardian, or authorized representative)**
If signing on behalf of the patient, you are stating that you are authorized to provide the required consents on behalf of the patient.

Print name of parent, guardian, or authorized representative	Phone Number	Relationship

PHARMACY USE ONLY

Vaccine	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot #	Expire Date	Name of Vaccine Administrator
COVID-19	☐ 1st Dose	☐ IM - L Arm ☐ IM - R Arm		☐ Moderna ☐ Janssen			

***Pharmacist** reviewing this form: _____ ***Pharmacist Signature**: _____

If **certified vaccinator** is different than the pharmacist who reviewed the form:

Name: _____ **Signature**: _____