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

Section 1: Vaccine Recipient Information (Required)

Last Name:	**First Name:**	**MI:**	**DOB:** **Age:**
Street Address:			**Gender:**
City:	**State:**	**Zip:**	**County in State:**
Phone Number:		**Email:**	

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino

Race: ☐ African American ☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Hispanic/Latino ☐ White ☐ Other

PCP Name:	**PCP Phone:**

Section 2: Vaccine Recipient Insurance Information (If you have received a previous vaccine at Conlin's, Proceed to Section 3)

***Do you have Prescription Insurance?** ☐ Yes ☐ No		***Are you the primary cardholder?** ☐ Yes ☐ No	
***Prescription Benefit Plan Name:**		**If no, provide primary card holder's DOB:**	
*Cardholder ID #:	RX Group ID Located on Insurance Card	Bin	PCN

Are you age 65 or older or Medicare Eligible? ☐ Yes ☐ No

NOTE: Required for all patients aged 65 and older, or Medicare Eligible. Refer to your Medicare Red, White, and Blue card.
Medicare number is required even if you have a Medicare Advantage Plan.

Medicare Part A/B ID Number

Medical Insurance:	Cardholder ID #:	Group ID:
Are you the primary cardholder? ☐ **Yes** ☐ **No**	If no, provide primary card holder's DOB:	

Section 3: 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 yes, which vaccine product did you receive?** ☐ **Pfizer** ☐ **Moderna** ☐ **Janssen**	☐	☐	☐
3. **Did you bring your Vaccination Record Card or other documentation?**	☐	☐	☐
4. **Have you ever had an allergic reaction to?**			
• 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: A component of the COVID-19:	☐	☐	☐
(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 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.)	☐	☐	☐

6. **Check all that apply to you:**

- ☐ Am a female between the ages of 18 and 49 years old
- ☐ Am a male between the ages of 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Have severe allergic reaction to something other than a vaccine or injectable therapy such as food pet, venom, environmental or oral medication Allergies:
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after COVID-19 infection
- ☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder, or take blood thinners
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ Have history of Guillain-Barré Syndrome (GBS)

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Section 4: Consent (Read and check each box below before signing)

☐	**I understand the benefits and risks of the COVID-19 vaccine as described in the Vaccination Information or Emergency Use Authorization (EUA) Fact Sheet or https://www.cdc.gov/vaccines/covid-19/eua a copy of which I was provided with this has been made available to me. 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 on the previous page or for 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 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 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 to have your vaccine administration fee paid for by The United States Health Resources & Services Administration's COVID-19 Program.

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.

I authorize Conlin's Pharmacy, Inc. to share my vaccination data with MIIS Registry

X	
***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.	Date

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

** PHARMACY USE ONLY **

Vaccine	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expire Date	Vaccinator
COVID-19	☐ Dose 1	☐ IM - L Arm		☐ Moderna			
	☐ Dose 2	☐ IM - R Arm		☐ Janssen			
	☐ Dose 3			☐ Pfizer			
	☐ Booster						

*Pharmacist reviewing this form:		Pharmacist Signature:
Name:		Vaccinator Signature: