my PHARMACY & OPTICAL
Where Hospitality Matters

COVID Immunization Consent Form

Name (as it appears on insurance card): _____ **Date of Birth:** _____ **Age:** _____ **Sex:** Male / Fem

Street Address: _____ **Room/Unit:**_____ **City:** _____ **State:** ____ **Zip Code:** _____

Email Address: _____@_____ **Phone:**_____ **SSN:** _____

Race: ☐ White ☐ Hispanic/Latino ☐ Black/African American ☐ Native American /Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other

MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. If you answer "YES", you may not be able to receive the COVID-19 vaccine.

Section 1: **If YES and further guidance is needed, refer to Pfizer website at www.PfizerMedInfo.com or call 1-800-438-1985 for vaccine information on vaccine temperature excursions, efficacy, safety, stability, dosage, vaccine ingredients, mechanism of action and administration. For overview for Vaccination Providers about Moderna COVID-19 vaccine refer to* **www.modernatx.com** *or call 1-866-MODERNA.*	***YES**	**NO**
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-BioNTech ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another Product		
• Have you received a complete COVID-19 vaccine series? (i.e., 1 dose Janssen or 2 doses of an mRNA vaccine [Pfizer-BioNTech, Moderna])?		
• Did you bring your vaccination record card or other documentation?		
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 caused hives, swelling, or respiratory distress, including wheezing.)* • A component of a COVID-19 vaccine, including either of the following: o Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures		
o Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids		
• 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 caused hives, swelling, or respiratory distress, including wheezing.)*		

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

Section 2: RELEASE AND ASSIGNMENT:

- **I have read or had explained to me the Vaccine Recipient Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient Emergency Use Authorization Fact Sheet for each vaccine visit the website www.cvdvaccine.com: or you may also visit the Local Health Unit or private provider to receive a printed copy of the EUA Fact Sheet. To read the Vaccine Recipient Emergency Use Authorization for Moderna COVID-19 vaccine visit the website** https://www.fda.gov/media/144638/download or (modernatx.com)
- **I give consent to this COVID-19 provider/staff for the individual named below to be vaccinated with COVID-19 vaccine.**
- **I hereby acknowledge that I have reviewed a copy of the Provider's Privacy Notice.**
- **I understand that information about this COVID-19 vaccination will be included in (SIMON) South Carolina Immunization Information System.**

To My Insurance Carrier(s):

- **I authorize the release of any medical information necessary to process my insurance claim(s).**
- **I authorize and request payment of medical benefits directly to this COVID-19 Provider.**
- **I agree that the authorization will cover all medical services rendered until I revoke the authorization.**
- **I agree that the photocopy of this form may be used instead of the original.**

My signature below indicates I have read, understand and agree to section ***2. Release and Assignment*** *of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).*

Signature of patient or guardian X:_____ Date:_____

Below is for pharmacy documentation

☐ **Pfizer-Monovalent(12+)** ☐ **Moderna Monovalent (12+)** *****MONOVALENT XBB.1.5***	**Monovalent Dose:** ☐ 1st Dose ☐ 2nd Dose ☐ 3rd Dose	**Route** ☐ IM	**Site Code** ☐ LA ☐ RA	**Lot Number:**

Administered by: _____ Title: _____ Date Given:_____

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