PROVIDER COVID-19 IMMUNIZATION CONSENT FORM

For COVID-19 Provider use only Clinic Name/Code: Location type: (clinic, health department, pharmacy, etc.,)___Pharmacy____
Address:__6802 Rogers Ave Ste 2_____City:___Fort Smith_____County:_____Sebastian_____
State:__Arkansas_____ Zip Code: _72903_____ Date of Service:_____

Person Receiving Vaccine:
(Legal) First Name: _____MI: _____ Last Name:_____
Date of Birth: _____/_____/_____

1. 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.

If YES refer to following websites at *www.PfizerMedInfo.com.* Moderna *www.modernatx.com.* Janssen *www.janssencovid19vaccine.com.* Refer to Pre-vaccination Checklist for COVID-19 vaccines to clarify questions: *www.cdc.gov/vaccines/covid-19/downloads/pre-vaccination-screening-form.pdf.*	***YES**	**NO**
Have you had a previous COVID-19 vaccine? If yes, what type and date?		
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?		
Have you ever had an allergic reaction to a COVID-19 vaccine or a COVID-19 vaccine component (including polyethylene glycol [PEG], which is found in some medications, or laxatives, and preparations for colonoscopy; or polysorbate, which is found in some vaccines, coated tablets, or IV steroids)?		
Have you ever had an allergic reaction that caused hives, swelling, respiratory distress (including wheezing) or anaphylaxis to a vaccine other than COVID-19 vaccine or an injectable medication that required treatment with epinephrine (EpiPen) or treatment at a hospital? Severe reaction or anaphylaxis to food, pet, venom, environmental, or oral medication allergies are not contraindications or precautions to vaccination with any COVID-19 vaccine.		
Do you have a bleeding disorder or are you taking a blood thinner?		
Have you received a hematopoietic cell transplant (HCT) or CAR-T-cell therapy since receiving COVID-19 vaccine? You should be revaccinated with a primary vaccine series at least 12 weeks after transplant or CAR-T-cell therapy.		
Did you develop myocarditis or pericarditis after the first dose of COVID-19 vaccine? You should not receive a subsequent dose of any COVID-19 vaccine. If you have developed myocarditis or pericarditis unrelated to an mRNA COVID vaccination, may receive COVID-19 vaccine after the episode has completely resolved.		
Are you immunocompromised? Do you have a condition that weakens your immune system? Are you receiving any immunosuppressive therapy? You are eligible to receive any FDA-authorized or FDA-approved COVID-19 vaccine unless you have a contraindication for some other reason.		
Have you had history of Heparin-Induced Thrombocytopenia (HIT) or Thrombosis with Thrombocytopenia Syndrome (TTS)? You may receive Pfizer-BioNTech or Moderna COVID-19 vaccine.		
Have you had history of Thrombosis with Thrombocytopenia Syndrome (TTS) following Janssen or any other adenovirus-vector (AstraZeneca) COVID-19 vaccine? Those who developed TTS after the initial Janssen vaccine should not receive a Janssen or any other adenovirus-vector COVID-19 vaccine booster dose. You may receive a mRNA COVID-19 vaccine.		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment or for post-exposure prophylaxis (PEP)? Defer vaccination 90 days after treatment and defer 30 days after PEP.		
Have you had Multisystem Inflammatory Syndrome (MIS)? Defer vaccination for at least 90 days. The decision for COVID-19 vaccination should be between the patient, their guardian, clinical team, or a specialist.		
Have you had history of Guillain-Barre Syndrome (GBS)? People with a history of GBS can receive any FDA-authorized or approved COVID-19 vaccine. People who had GBS after receiving Janssen vaccine should receive a Pfizer-BioNTech or Moderna COVID-19 vaccine booster at least 8 weeks after the Janssen dose.		
NOTE: CDC has made a clinical preference for persons 18 years and older to receive an mRNA COVID-19 vaccine over Janssen COVID-19 vaccine. Patients who cannot or unwilling to receive an mRNA vaccine will be able to access Janssen COVID-19 vaccine. The Janssen Fact Sheet must be provided and explained to the recipient or parent/legal representative about the risks and benefits and address any questions or concerns that the recipient or parent/legal representative may have prior to the vaccination. Recipients of Janssen COVID-19 vaccine should seek immediate medical attention if they develop shortness of breath, chest pain, leg pain or swelling, persistent abdominal pain, severe or persistent headaches or blurred vision, easy bleeding beyond the vaccination site within 30 days of a Janssen vaccination.		
NOTE: A second dose of COVID-19 vaccine **may** be due in 21 days or 28 days after initial vaccine. Refer to your COVID-19 vaccination record card for proof of initial vaccine date and for second dose due date. Contact your vaccination provider, PCP, or your ADH Local Health Unit in 21 days or 28 days for more information.		

2. **RELEASE AND ASSIGNMENT:** Please read the section on the reverse side of this form**.** The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right.

Please sign here

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/Parent/Guardian:

_____Date_____

Patient Information:

(Legal) First Name _____ MI_____

Last Name _____Date of Birth _____
Age_____ Gender: M____ F____ Phone _____

Street Address _____ P.O. Box_____

City _____Zip _____ State _____

Race: Asian ____ Black/African American _____ Native American / Alaska Native ____

Native Hawaiian / Other Pacific Islander ____ White ____ Other____

Ethnicity: Hispanic / Latino ____ Non-Hispanic____

Social Security Number _____

Signature of Patient / Parent / Guardian _____

For Children! Name of Primary Care Provider _____

I request the vaccine to be given to me or to the person named above, a minor for whom I represent, and I am authorized to sign this consent form. I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet (https://www.cdc.gov/vaccines/covid-19/eua/index.html or https://lawsdrugstore.com/forms) a copy of which I was provided with this consent form (online or in print). I have had a chance to ask questions that were answered to my satisfaction. 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. If insured, I authorize the pharmacy to bill my insurance on my behalf for the immunization – understanding that I will not incur any costs. If uninsured, I attest that I do not have any insurance, including, but not limited to Medicare, Medicaid, or any other private or government-funded benefit plan. If uninsured, I authorize the pharmacy to use my social security number, state identification number, or driver's license number to bill the United States Health Resources & Services Administration's COVID-19 Program on my behalf for the immunization – understanding that I will not incur any costs. I understand that at this time, some COVID-19 vaccines require 2 doses given 21-28 days apart dependent on the manufacturer. If this is my first dose of the COVID-19 vaccine and a second dose is required (Pfizer and Moderna only), I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the series. I understand that information about this vaccination will be included in (WebIZ) Arkansas Immunization Information System. I acknowledge offer of the Laws Drug Store Notice of Privacy Practices (online at https://lawsdrugstore.com/forms or in print).

Vaccine Given (Please Check One)				
____ Pfizer-BioNTech Adult (12 & up) ____ Pfizer-BioNTech Kids (5-11)			____ Moderna ____ Janssen (Johnson & Johnson)	
Route	Site Code	Dosage mL	MFG Code	Lot Number
__ IM				

Signature of Vaccine Administrator _____Pharm/Tech

Date Vaccine Administered _____ / _____ / _____