Thrifty MedPlus Pharmacy COVID-19 Vaccine Consent Form

Patient Information (Vaccine Recipient):

Name (Last)	(First)	**Date of Birth**	**Age**	**Gender** ☐M ☐F
Address		**Race** ☐White ☐Black ☐Asian ☐Pacific Islander ☐Native American ☐Other	**Ethnicity** ☐Hispanic ☐Not Hispanic	
City	**State**	**Zip**	**Phone Number**	
Primary Care Provider Name:				
Emergency Contact Name:	**Relation:**	**Phone Number:**		

Screening Questions:

Question	YES	NO	Don't Know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 Vaccine? • If yes, when was your last dose? _____	☐	☐	☐
3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? (This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)	☐	☐	☐
4. Have you received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
5. 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** • **A previous dose of COVID-19 Vaccine**	☐ ☐	☐ ☐	☐ ☐
6. 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.)	☐	☐	☐

7. Check all that apply to you:

- ☐ **I have a history of myocarditis or pericarditis**
- ☐ **I have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)**
- ☐ **I have a history of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)**
- ☐ **I have a history of thrombosis with thrombocytopenia syndrome (TTS)**
- ☐ **I have a history of Guillain-Barré Syndrome (GBS)**
- ☐ **I have a history of COVID-19 disease within the past 3 months**
- ☐ **I have been vaccinated with the monkeypox vaccine in the last 4 weeks**

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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, a copy of which I was provided via the QR code on this consent form, or a printed copy upon request. 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.

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☐ 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.

Signature of Person to Receive Vaccine & EUA /VIS (or Signature of Parent/Guardian if Patient is < 18 years old)

Signature: _____ **Date:** _____

*****PHARMACY USE ONLY*****

Vaccine	Dose	Route	Vaccine Manufacturer	Lot Number	Expiration Date	Date Dose Administered	Date on VIS/EUA
COVID-19	☐ 0.3mL ☐ 0.5mL	☐ IM - L Arm ☐ IM - R Arm	☐ Pfizer ☐ Moderna				

Pharmacist Name who reviewed this form: _____ **Pharmacist Signature**: _____

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

Name: _____ **Signature**: _____

☐ Reported to TennIIS