COVID-19 vaccines administered by appointment only.
www.hillcrestpharmacy.net/book-online

COVID-19 VACCINE INTAKE & CONSENT FORM

HILLCREST PHARMACY

PATIENT INFORMATION

Last Name | First Name | DOB | Gender

Address | City | State | Zip

Cell Phone # | Place of Employment | Mother's First Name

Is this the patient's ◯ FIRST or ◯ SECOND dose of the COVID-19 Vaccine?

INSURANCE INFORMATION

◯ I have presented my health insurance card to the pharmacy

Medicare (if eligible):

Medicare A/B ID # (refer to your red, white & blue Medicare Card)

If uninsured, you must check the box below to attest that the following is true and accurate.
◯ I do not have any insurance, including but not limited to Medicare, Medicaid, or any other private or government-funded health benefit plan.
In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, **please provide either (a) a valid social security number (b) a state identification number & state OR (c) a driver's license number and state.**

Social Security # or State ID # & State or Driver's License # & State

COVID-19 SCREENING QUESTIONS	YES	NO	Don't Know
1. In the past 90 days, have you tested positive for COVID-19, or are you currently being monitored for COVID-19?			
2. In the past 2 weeks, have you had contact with anyone who tested positive for COVID-19?			
3. Have you had new onset of fever, chills, cough, shortness of breath, fatigue, muscle or body aches, headache, loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?			

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IMMUNIZATION SCREENING QUESTIONS	YES	NO
1. Are you sick today (ex: a cold, fever or acute illness)		
2. Do you have allergies or reactions to any foods, medications, vaccines or latex? If yes, please specify:		
3. Have you ever had a serious reaction after receiving a vaccination?		
4. Have you had a seizure or a brain or other nervous system problem?		
5. For women, are you pregnant or is there a chance you could become pregnant during the next month?		
6. Have you received any other vaccinations in the last 4 weeks?		

Please read the following statement and sign below on the signature line.
I have read or have had explained the information provided about the vaccine I am to receive. I have been given the Vaccine information sheet or the fact sheet corresponding to the vaccine I am being given. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of vaccination and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I understand that I should remain in the vaccine administration area for 15 minutes after receiving the vaccination to be monitored for any potential adverse reactions. I understand that if I experience side effects, I should do the following: call pharmacy, contact doctor, call 911. I do hereby authorize Hillcrest Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare, Medicaid or the HRSA COVID-19 program for uninsured 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.

X_____

Signature of patient to receive vaccine (or parent, guardian, or authorized representative) Date

You must go to www.hillcrestpharmacy.net/book-online to schedule your appointment to get vaccinated.

Vaccine supply is limited. Please keep your appointment or call if you need to cancel or change it. Additionally, due to vaccine requirements; we may call you to see if you can come earlier, later or to a nearby location. If you miss an appointment, no doses will be held to guarantee your dose.*

VACCINE ADMINISTRATION INFORMATION for Immunizer/Pharmacist use only

	Vaccine	MFR	Lot #	Site	Amt Admin	VIS Date	Date Admin	Administrator
	COVID-19 Vaccine Dose #1	Moderna		RA/LA	0.5ml	12/20		
	COVID-19 Vaccine Dose #2	Moderna		RA/LA	0.5ml	12/20		