COVID-19 VACCINE INTAKE & CONSENT FORM

HILLCREST PHARMACY

PATIENT INFORMATION

Last Name	First Name	DOB	Gender
Address	City	State	Zip
Cell Phone #			Race/Ethnicity

Dose: ◯ First ◯ Second ◯ Third

Which vaccine would you like? ◯ Moderna ◯ Pfizer

INSURANCE INFORMATION

IF INSURED:

◯ 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

□ *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 with this Consent Form. 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.*

□ 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.

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 received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?		
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?		
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?		

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

VACCINE ADMINISTRATION INFORMATION for Immunizer/Pharmacist use only

	Vaccine	MFR	Lot #	Site	Amt Admin	Given Fact Sheet	Date Admin	Administrator
	COVID-19 Vaccine Dose #1	☐ Moderna ☐ Pfizer		RA/LA				
	COVID-19 Vaccine Dose #2	☐ Moderna ☐ Pfizer		RA/LA				
	COVID-19 Vaccine Dose #3	☐ Moderna ☐ Pfizer		RA/LA				