COVID-19 VACCINE SCREENING AND CONSENT FORM

PATIENT INFORMATION

(PLEASE PRINT CLEARLY)

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	DOB:	AGE:	SEX:

RACE/ETHNICITY: AMERICAN INDIAN/ALASKA NATIVE | BLACK/AFRICAN AMERICAN | HISPANIC/LATINO | NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER | WHITE | ASIAN | OTHER

HOME ADDRESS:	CONTACT PHONE:

CITY:	STATE:	ZIP CODE:

PRIMARY CARE PHYSICIAN:	PHYSICIAN PHONE:

HAVE YOU HAD ANY OF THE FOLLOWING VACCINES:	Yes	No	Don't Know
Pneumococcal Vaccine (pneumonia)			
Shingles Vaccine			
Tdap (Whooping Cough) Vaccine			
RSV (respiratory syncytial virus)			

SCREENING QUESTIONNAIRE

(The following questions will help us determine your eligibility to be vaccinated today. If you answer "yes" to any question, it does not necessarily mean that you should not be vaccinated. Additional questions may be asked by vaccinator)

ALL VACCINES	Yes	No	Don't Know
Are you feeling sick or experiencing a moderate to high fever today?			
Do you have any allergies to medications, food (i.e. eggs), latex, vaccine component (e.g. neomycin, formaldehyde, gentamicin, thimerosal, bovine proteins, phenol, polymyxin, gelatin, baker's years or yeast)?			
Have you ever had a serious reaction to any vaccinations (excluding COVID-19 vaccines), including fainting and/or feeling dizzy?			
Have you ever had a health problem with lung, heart, kidney, or metabolic disease (e.g. diabetes), asthma, or a blood disorder? If yes, please list:			
Do you have a weakened immune system caused by something such as HIV infection, cancer, immunosuppressive medications, or high dose steroids?			
Do you have a bleeding disorder or are you taking a blood thinner?			
Have you ever had a seizure disorder for which the patient is on seizure medication(s), a brain disorder, Guillain–Barré syndrome (a condition that causes paralysis) or other nervous system problem?			
Have you received any vaccines in the last 14 days?			
Do you smoke cigarettes or use any other tobacco containing products?			
Are you pregnant, considering becoming pregnant in the next month, or currently breastfeeding?			
COVID-19 VACCINE	Yes	No	Don't Know
Have you received at least 2 doses of any COVID-19 vaccine in the past?			
Has it been longer than 2 months since you received your last dose of any COVID-19 vaccine?			
Have you ever had a severe allergic reaction to a component of COVID-19 vaccine (including polyethylene glycol, which is found in some medications such as laxatives and colonoscopy preparations), polysorbate, or a previous dose of COVID-19 vaccine?			
Have you had a positive COVID-19 test or been told that you have COVID-19 by a doctor within the last three months?			

*If patient is **not** receiving a COVID-19 vaccine at this time, please utilize the general vaccine screening form instead*

I certify that I am (a) the patient and at least 18 years of age or (b) the parent or legal guardian of the patient. Further, I hereby consent to the healthcare provider of Curtis Pharmacy to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. On behalf of myself, my heirs, personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees form any and all liabilities or claims whether known or unknown arising out of, in connection with, or in anyway related to the administration of the vaccine(s) listed above. I acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. I acknowledge that, depending upon my state's law, I may prevent the disclosure of my immunization information by this applicable Provider to the State Registry by using this opt-out form. The Provider will, if my state permits, provide me with an Opt-out form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the Provider reporting my immunization information to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information as required or permitted by law. I voluntarily authorize and direct my healthcare provider at Curtis Pharmacy to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at Curtis Pharmacy, my primary care physician, my insurance, and/or state or federal registries, where required, for the purpose of treatment, payment or other healthcare operations. I further agree to be fully financially responsible for any cost sharing amount, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service.

PATIENT NAME: _____

PATIENT SIGNATURE:_____ DATE: _____

☐ Please bring your medical insurance, prescription insurance card and your red, white, and blue Medicare card (if applicable) to your vaccination appointment

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PHARMACY USE ONLY

Vaccine	NDC	Manufacturer	Dose	VIS	Lot #	Exp. Date	Site of Admin	Route of Admin

PHARMACIST SIGNATURE: _____

ADMINISTRATION DATE: _____ DATE VIS GIVEN TO PATIENT: _____