

# Riverside Remedies Pharmacy

## COVID-19 Vaccine Immunization Screening and Consent Form

### Section I. Personal Information

First Name		Last Name	
DOB	Gender	Marital Status	Mother's Maiden Name
Home Address		City, State, County, ZIP	
Telephone	<input type="checkbox"/> Mobile	<input type="checkbox"/> Landline	Parent/Guardian/Surrogate
Ethnicity	<input type="checkbox"/> DECL - Declined <input type="checkbox"/> HIS - Hispanic <input type="checkbox"/> NHL - Non-Hispanic <input type="checkbox"/> UNK - Unknown		
Race	<input type="checkbox"/> AIA - Native American or Alaskan <input type="checkbox"/> ASN - Asian <input type="checkbox"/> BAA - African American or Black <input type="checkbox"/> DECL - Declined <input type="checkbox"/> NHP - Native Hawaiian or Pacific Islander <input type="checkbox"/> OTH - Other or Multiracial <input type="checkbox"/> WHT - White		
Medicare Number	Primary Care Physician and Telephone Number		
Social Security Number			

### Section II. Screening Questionnaire

1	Are you feeling sick today?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
2	In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
3	Have you been treated with antibody therapy for COVID-19 in the past 90 days? If yes, when did you receive the last dose?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
4	Have you ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing, due to any vaccine or shot?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
5	Are you pregnant or considering becoming pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
6	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease, or any other condition that weakens the immune system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
7	Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or recent radiation treatments?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
8	Have you previously received a COVID-19 vaccine? <input type="checkbox"/> Yes (Date received _____) <input type="checkbox"/> No			

### Section III. Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known potential benefits of the vaccine outweigh the known and potential risks.

### Section IV. Signature

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, and two doses of this vaccine will need to be administered in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I authorize release of all information needed (including but not limited to medical records) as needed for other public health purposes, including reporting to applicable vaccine registries.

-----  
Recipient/Surrogate/Guardian Signature

Date/Time

Relationship to patient, if other than recipient

-----  
Interpreter Signature

Date/Time

Relationship to Patient

TO BE COMPLETED BY PROVIDER					
Vaccine	Administration			EUA Date	Lot Number
Pfizer/BioNTech	<input type="checkbox"/> First dose	<input type="checkbox"/> Second dose	<input type="checkbox"/> Third dose		
Moderna	<input type="checkbox"/> First dose	<input type="checkbox"/> Second dose	<input type="checkbox"/> Third dose	12/20	
Janssen	<input type="checkbox"/> Single dose				

Administration Site:     Left Deltoid     Right Deltoid     Other \_\_\_\_\_  
Dosage:                     0.5 mL                     0.25 mL

- I have reviewed side effects with the patient (and parent, guardian, or surrogate, as applicable).
- I confirm that the patient (and their surrogate, if applicable), was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered correctly and to the best of my ability.

-----  
Vaccinator Signature