Riverside Remedies Pharmacy

COVID-19 Vaccine Immunization Screening and Consent Form

Section I. Personal Information

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

Section II. Screening Questionnaire

1	Are you feeling sick today?	□ Yes	□ No	□ 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?	□ Yes	□ No	□ 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?	□ Yes	□ No	□ 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?	□ Yes	□ No	□ Unknown
5	Are you pregnant or considering becoming pregnant?	□ Yes	□ No	□ Unknown
6	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease, or any other condition that weakens the immune system?	□ Yes	□ No	□ 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?	□ Yes	□ No	□ Unknown
8	Have you previously received any COVID-19 vaccine? □ Yes, Type: _____ Most recent date received:_____ □ No.			

(TURN ↷ OVER)

Section III. Emergency Use Authorization

The FDA has made COVID-19 vaccines 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 that two doses of this vaccine will need to be administered in order for it to be effective. I understand that additional doses may become available and appropriate for maintaining adequate effect in the future. 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/Parent/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**			**Fact Sheet**	**Lot Number**
Pfizer/Adult	□ First dose	□ Second dose	□ Third dose	10/29/21	
Pfizer/Pediatric	□ First dose	□ Second dose	□ Third dose	10/29/21	
Moderna	□ First dose	□ Second dose	□ Third dose	10/20/21	

Administration Site: □ Left Deltoid □ Right Deltoid

Dosage: □ 0.5 mL □ 0.25 mL □ 0.20 mL

□ I have reviewed side effects with the patient (and parent, guardian, or surrogate, as applicable), and 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 have been answered correctly and to the best of my ability.

_____

Vaccinator Signature