## COVID-19 VACCINE SCREENING & CONSENT FORM ☐ PA-SiiS ☐ Pioneer

### GENERAL PATIENT INFORMATION (PLEASE PRINT- MUST BE LEGIBILE)

**Name: First: _____ Last: _____ Middle Initial: _____**

**DOB: ____/____/_____ Phone: _____**

**Address (REQUIRED):_____ City: _____ State: ____ Zip: _____**

| **Sex** | **Race** | **Ethnicity** | Is this the patient's first or second dose of the COVID-19 vaccination? |
|---|---|---|---|
| ☐ **Male** | ☐ American Indian | ☐ Hispanic or Latino | ☐ **First Dose** |
| ☐ **Female** | ☐ Asian | ☐ Not Hispanic or Latino | ☐ **Second Dose** |
| **Confirm Age Group:** | ☐ Black or African American | ☐ Unknown | When and where was the first dose? (If applicable): |
| ☐ **18+** | ☐ White | | _____ |
| ☐ **16-17** | ☐ Pacific Islander | | |
| ☐ **12-15** | ☐ Unknown | | |

**INSURANCE INFORMATION** *********_**PLEASE ATTACH A COPY OF YOUR MEDICARE CARD (>65) OR INSURANCE**_********

**(PLEASE DO NOT GIVE US YOUR MEDICAL CARD, WE NEED A PRESCRIPTION CARD THAT HAS A BIN NUMBER)**

***If over 65 Medicare ID #:*** _____ ***Social Security Number (SSN):*** _____

Primary Insurance ID #: _____ Pharmacy Phone #: _____

RxBin: _____ RxPCN: _____ RX Group #: _____

☐ Do **NOT** have insurance - **Required**: ***Social Security Number (SSN):*** _____

### COVID-19 VACCINE SCREENING QUESTIONS

| Please check **YES** or **NO** for each of the following questions | **YES** | **NO** | **Don't Know** |
|---|---|---|---|
| **1. Are you feeling sick today?** | | | |
| 2. Have you ever received a dose of COVID-19 Vaccine? | | | |
| • If **YES**, which vaccine did you receive? ☐ Pfizer ☐ Moderna ☐ Other: _____ | | | |
| 3. **Have you ever had an allergic reaction to:** (This would include a severe allergic reaction [e.g. anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) | | | |
| • A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures. | | | |
| • Polysorbate | | | |
| • A previous dose of COVID-19 vaccine or another injectable medication or vaccine | | | |
| 4. **Have you ever felt faint or passed out after or during a vaccination or while giving blood? (Please notify the vaccinator BEFORE receiving your vaccine)** | | | |
| 5. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies. _____ | | | |
| **6. Have you received any vaccine in the last 14 days? (Contraindication to any COVID vaccine)** | | | |
| 7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? When was your positive test _____ | | | |
| 8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? | | | |
| 9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs (e.g. prednisone) or therapies? | | | |
| 10. Do you have a bleeding disorder or are you taking a blood thinner? | | | |
| 11. Are you pregnant or breastfeeding? | | | |

**NAME: _____ DOB: _____**

- ✓ I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 12 years of age; or (c) authorized to consent for vaccination for the patient named above. Furthermore, I hereby give my consent to Rann Pharmacy or its associates to administer the COVID-19 vaccine.

- ✓ I understand that this product has not been approved or licensed by the FDA, but has been authorized for emergency use by the FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years or age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization is revoked sooner.

- ✓ I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine that 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.

- ✓ I acknowledge that I have been advised to remain near the vaccination location for **approximately 15 minutes** (or more, in specific cases) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.

- ✓ On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Rann Pharmacy and their staffs, agents, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.

- ✓ I acknowledge that: (a) I understand the purposes/benefits of Pennsylvania's immunization registry and (b) Rann Pharmacy will include my personal immunization information in the PA-SIIS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.

- ✓ I further authorize the Rann Pharmacy to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to the Rann Pharmacy with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if the Rann Pharmacy invoices me after the time of service, upon receipt of such invoice.

- ✓ I acknowledge the receipt of the Notice of Privacy Rights.

**Patient/Authorized Representative (ex. parent if <18 or Power of Attorney)**:**

_____ _____ **Date: ___/___/_____**

(Printed Name) (Signature)

**FOR VACCINATOR ONLY: PATIENT'S TEMPERATURE: _____**

| *Vaccine Name* | *Manufacturer* | *LOT* | *EXP. DATE* | *Dosage* | *Site* | *Date of EUA Fact Sheet* |
|---|---|---|---|---|---|---|
| COVID19-PFR-01 | *Pfizer* | | | **0.3 ML** | RIGHT Deltoid (RD)<br>LEFT Deltoid (LD) | |

Vaccinator Name: _____ Signature: _____ Date: ___/___/____