your pharmacy solution
703 Ginesi Drive, Morganville, NJ 07751
(732) 617-8686

COVID-19 VACCINE SCREENING AND CONSENT FORM

3RD DOSE /BOOSTER

Last Name	**First Name**	**Date of Birth – Age**	**Gender (M / F)**
Phone Number	**E-Mail**	**Race/Ethnicity**	**Medicare ID#**
Address	**City**	**State**	**Zip**
Primary Care Provider (PCP) Name	**PCP Address**	**PCP Phone**	

Guardian/Surrogate/P.O.A. (if applicable, please print)	Phone

POTENTIAL CONTRAINDICATIONS				
1.	Are you feeling sick today? (Fever, Respiratory Infection, or other moderate/severe illness)	□ **Yes**	□ **No**	
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 for COVID-19 infection or exposure?	□ **Yes**	□ **No**	
3.	Have you received antibody therapy (monoclonal antibodies or convalescent plasma) for COVID-19 in the past 90 days (3 months)?	□ **Yes**	□ **No**	
4.	Have you had any vaccines in the past 14 days (2 weeks) including flu shot?	□ **Yes**	□ **No**	
5.	Have you ever had a serious or life-threatening allergic reaction (e.g., anaphylaxis), such as hives or difficulty breathing, to any COVID-19 vaccine or any component of the vaccine, including mRNA, lipid nanoparticles or polyethylene glycol (PEG)?	□ **Yes**	□ **No**	
6.	Have you tested positive for COVID-19 in the past 14 days (2 weeks)?	□ **Yes**	□ **No**	
7.	Are you under 18 years of age?	□ **Yes**	□ **No**	
POTENTIAL CONSIDERATIONS				
1.	Have you ever had a serious or life-threatening allergic reaction (e.g., anaphylaxis), such as hives or difficulty breathing, to any vaccine or shot/injection?	□ **Yes**	□ **No**	
2.	Have you ever had a serious or life-threatening allergic reaction (e.g., anaphylaxis), such as hives or difficulty breathing, due to any cause? (Including medications, foods, latex, or any item.)	□ **Yes**	□ **No**	
3.	Are you currently pregnant or breastfeeding?	□ **Yes**	□ **No**	
4.	Do you have cancer, leukemia, HIV/AIDS, a history or autoimmune disease or any other condition that weakens the immune system?	□ **Yes**	□ **No**	
5.	Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer of rheumatologic drugs, or have you had any radiation treatments?	□ **Yes**	□ **No**	
6.	Do you have a bleeding disorder or taking any blood thinner or anticoagulants?	□ **Yes**	□ **No**	
7.	Have you received a prior dose of COVID-19 Vaccine? If so, provide date.	□ **Yes**	□ **No**	**Date:**_____

***If you have ever had an allergic reaction to a vaccine/injectable (question 1) you will not be permitted**
**** If you answered yes to questions 1-5 please consult with your healthcare provider before receiving vaccine**
***** If you are pregnant or breastfeeding please also provide a note at the time of vaccination from your OBGYN confirming you should receive the vaccine**

Nurse Reviewing Form:_____**Signature:**_____**Date:**_____

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Last Name: _____First Name:_____Date of Birth:_____

CONSENT FOR VACCINATION

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. I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 1;8 years of 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)(l) of the FD&C Act unless the declaration is terminated or authorization revoked sooner. 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 and potential benefits of the vaccine outweigh the known and potential risks. I certify that I am: (a) the patient and at least 18 years of age; or (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age; and (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to IPPC Pharmacy or its agents to administer the COVID-19 vaccine.

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet(s) or patient fact sheet corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. If the recipient has previously had a severe allergic reaction in the past for any reason, I agree to wait near the clinic location for 30 minutes after receiving the vaccine in designated area. I understand if I experience side effects that I should do the following: contact doctor, call 911, or go to hospital. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I acknowledge that I have received and reviewed the Vaccine Information Statement or Emergency Use Authorization Information Sheet. I will/have reviewed my answers to the questions above with the vaccinator. I understand that the COVID-19 vaccine is a two-part vaccine series. By signing this consent, I am agreeing that I will receive the first and second part of the vaccine series, and understand the second dose maybe required to be effective. I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. 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 vaccine. 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).

AUTHORIZATION TO REQUEST PAYMENT: I understand there will be no cost to me for this vaccine. I do hereby authorize IPPC Pharmacy and/or its agents to release information, submit a claim, and request payment. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider. I certify that the information given to me in applying for payment under my insurance provider, Medicare or Medicaid, other third parties who are financially responsible for my care, or the HRSA COVID-19 Program for Uninsured Patients, are correct. I authorize release of all records to act on this request. I assign and request that payment of authorized benefits be made on my behalf to IPPC Pharmacy or its agents with respect to the above requested items and services.

DISCLOSURE OF RECORDS: I understand the IPPC Pharmacy may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at IPPC Pharmacy Vaccination Sites (if applicable), IPPC Pharmacy and its agents, my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment payment or other health care operations (such as administration or quality assurance). I also understand that IPPC Pharmacy will use and disclose my health information as set forth in the IPPC Pharmacy Notice of Privacy Practices (by requesting a paper copy from IPPC Pharmacy, 703 Ginesi Drive, Morganville, NJ 07751). If I am receiving a vaccine through a vaccine clinic, I understand that my name, vaccine appointment date and time will be provided to the clinic coordinator. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the State of New Jersey, IPPC Pharmacy, and their staff agents, successors, divisions, affiliates, subsidiaries, officers, directors, 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/herein.

Patient/Surrogate/Guardian/Power of Attorney (Signature) Date / Time **Print: Relationship to Patient**

(BELOW FOR CLINIC USE ONLY)

Administration Facility Name: IPPC PHARMACY

Nursing Vaccine Administration Information				
Vaccine Manufacturer	**Administration**	**EUA Fact Sheet**	**Lot Number**	**Expiration Date**
MODERNA	□ **First Dose** □ **Second Dose**			
JOHNSON & JOHNSON	□ **Dose**			
BioNTech/Pfizer	**THIRD DOSE**			

Dose: 0.5mL	**Route: IM**		
Administration Site:	□ **Left Deltoid**	□ **Right Deltoid**	□ **Other**

Vaccinator Name: _____Signature:_____Date:_____