COVID VACCINATION CONSENT FORM

At this time, we administering the Johnson & Johnson Janssen vaccine.

First Name: ____________________ Middle Initial: ______ Last Name:_________________________

Date of Birth: ____________________ Age:___________ Phone: ____________________________

Gender: Male or Female Email: ____

Address: ____________________ City: ______________________ State: _____ Zip: __________

Primary Care Doctor: _____________________________ City: _______________ State: _________

Mother's Maiden Name: ___________________________ Height: _________ Weight: __________

Emergency Contact: ____________________ Relation: ______________ Phone #: ______________

Will this be your first dose of the COVID-19 Vaccine? YES NO

- If second dose, when was your first dose? ________________
- If second dose, which vaccine did you receive? Pfizer or Moderna

Ethnicity: (Please check one)

- Hispanic/Latino
- Non-Hispanic
- Unknown
- Prefer Not to Answer

Race: (Please select one)

- African American
- American Indian
- Asian
- Caucasian
- Native Hawaiian/Other Pacific Islander
- Other
- Prefer not to answer

Insurance Type (check all that apply)

***** You must bring this card with you to your vaccination appointment for verification*****

- ○ Medicaid
- ○ Medicare
- ○ Medicare Part D
- ○ Private Insurance
- ○ No Insurance

☐ I authorize Economy Pharmacy to bill my insurance on my behalf for the immunization.

In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for uninsured patients, please provide **ONE** of the following:

Social Security Number: ___________________________

State identification number and state of issuance: _______________________________________

Driver's license number and state of issuance: ____

***** You must bring this card with you to your vaccination appointment for verification*****

☐ I understand that after submitting this completed form to the pharmacy location, I will be contacted to schedule my vaccination appointment as vaccines are available. I also understand that turning in this form does not guarantee me a vaccine.

☐ I agree to wait with the immunization team 15-30 minutes after my vaccination has been administered.

At which store would you like to reserve your vaccination appointment?

Muskogee

- ○ West- 3414 W Okmulgee

Tulsa

- ○ South-10120 E 91st St

Immunization Questionnaire:

Please mark the correct box for each question.	Yes	No	Don't know or N/A
In the past two weeks, have you had a known exposure with anyone who tested positive for COVID-19?			
Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headaches, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?			
Are you feeling sick today?			
Have you ever had an allergic reaction* to 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?			
Have you ever had a reaction to polysorbate which is found in some vaccines, film coated tablets, and intravenous steroids?			
Have you ever had an allergic reaction* to a previous dose of COVID-19 vaccine?			
Have you ever had an allergic reaction* to another vaccine (other than COVID-19 vaccine) or an injectable medication?			
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, venom, environmental, or oral medication allergies.			
Have you received any vaccine in the last 14 days?			
Have you ever had a positive test for COVID-19 or has a healthcare provider ever told you that you had COVID-19?			
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? Note: Monoclonal antibodies does not include antibiotics that you would be prescribed and fill at a pharmacy?			
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
Do you have a bleeding disorder or are you taking a blood thinner?			
For Women: Are you pregnant or breastfeeding?			
Do you have dermal fillers?			

* 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.
I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA), a copy of which is available below according to the manufacturer. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent and for whom I am authorized to sign this Consent and Release.

Johnson & Johnson-Janssen Emergency Use Authorization: https://www.fda.gov/media/146305/download

___________________________________ ________________________
Signature Date

I have received a copy of the notice of Privacy Practices. I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the Pharmacy and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

___________________________________ ________________________
Signature Date

FOR PHARMACY USE ONLY:

☐ I have reviewed Patient Information and Questionnaire for Immunization with the patient prior to administering the vaccine, and they have indicated that all answers are accurate as of the day of administration.

☐ The patient did not have an adverse reaction after 15 minutes

Blood Pressure: ____________________ Pulse: ______ Temperature: ____________________

Vaccine Manufacturer: Pfizer Janssen (J&J) Other

Date Removed from -80*C: __________________ Time Removed from -80*C: _____________

Vaccine Lot Number: _________________________ Expiration Date: _____________________

Dosage: _________________________________ Injection Site: Left Deltoid___________________

____________________________________ ____________________ ____________________
Signature of Licensed Administrator Date Administered Time Administered

Name of Licensed Administrator: ____