Whiting Pharmacy Informed Consent for Immunization with COVID-19 Vaccine

First Name: _____ Last Name: _____ Date of Birth: _____ Age: _____ Gender: _____
Phone # _____ Shot Requested Today: _____ 1st Dose / 2nd Dose / 1st Booster / 2nd Booster
Previously Given: Pfizer / Moderna / Johnson Date of Last Dose: _____ Reaction? _____
Home Address: _____
City: _____ State: _____ Zip: _____ **Last 4 of SSN # _____**
Known Allergies:_____
Race: ☐Asian ☐Black/African American ☐ Native American/Alaska Native ☐ White ☐Pacific Islander/Hawaiian ☐Other
Ethnicity: ☐Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline to State (Unknown)

Screening Questionnaire: *Please Answer questions by checking boxes*		Yes	No
1.	Are you sick today?		
2.	a. 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, and includes an allergic reaction that caused hives, swelling, or respiratory distress (including wheezing)		
	b. A reaction to a component of a COVID-19 vaccine, including either of the following:		
	- Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures		
	- Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids?		
3.	Have you ever had an allergic reaction to any vaccine? If yes, which vaccine? _____		
4.	Please check yes or no:		
	- Am a female between ages 18 to 49 years old		
	- Am a male between ages 12 and 29 years old		
	- Have a history of myocarditis or pericarditis		
	- Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental, or oral medications		
	- Had COVID-19 and was treated with monoclonal antibodies or convalescent serum		
	- Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection		
	- Have a weakened immune system (HIV, cancer) or take immunosuppressive drugs or therapies		
	- Have a bleeding disorder		
	- Have a history of heparin-induced thrombocytopenia (HIT)		
	- Am a currently pregnant or breastfeeding		
	- Have received dermal fillers		
	- History of Guillain-Barre Syndrome (GBS)		
5.	**Any recent vaccines given? ☐ Flu ☐ Prevnar 13 ☐Pneumovax ☐Zostavax Date Received: _____**		

Informed Consent: Please read and sign.

By my signature below, I consent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist or technician, or other authorized person, where permitted by law or state/federal guidance, employed, or contracted by Whiting Pharmacy and to be contacted at the number provided above regarding other immunizations for which I am due or eligible to receive. I also release Whiting Pharmacy and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting, or arising from my receipt of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination and understand that I am obligated to pay for all products and services received, if applicable. 2) I may be responsible for payment after the date of service if the product or service is billed to my medical benefit. 3) I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient 4) I will immediately alert the pharmacist of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine. 5) I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects. 6) I should remain in observation for 15 minutes unless I have a history of an immediate allergic reaction of any severity to a vaccine or injectable therapy or if I have a history or anaphylaxis in which case, I should remain in observation for 30 minutes. If I leave the area without waiting, I acknowledge that I am doing so at my own risk against the advice of the professional who administered the vaccine. 7) I have read, or have read to me, the Vaccine Information Sheet (VIS) or Emergency Use Authorization (EUA) provided for the vaccine(s) administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the risks and benefits of the vaccine(s) 8) I have been offered and/or provided a copy of the company's Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act (HIPPA) 9) This vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting by my pharmacy or its business associate to an immunization registry, which may share my immunization data with others, and to my primary care physician, or the local Department of Health, if applicable, and I authorize these disclosures.

→ Signature of Patient or Parent/Guardian of Minor Patient: _____ Date: _____

For Pharmacy Use Only: Given by: _____ Administration Date: _____ ☐NPP Rph offered counseling: accepted/declined.
RPH Signature indicates (1) VIS/EUA provided (2) Counseling offered and (3) Patient Eligibility Verified): _____