COVID-19 Vaccine Screening Questionnaire and Consent Form

Legal Name: ____ **DOB**:________________**Age**:________

Full Address: ____

Phone: (   ) ____ **SSN**: ____

Insurance: None / Private / Medicare (please provide RED,WHITE,&BLUE Medicare card)
Please Circle *(Answering is optional. Used for data collection)*
Gender: Female / Male / Other
Race: Asian / Black or African-American / White / American Indian or Alaskan Native / Native Hawaiian or Pacific Islander
Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Unknown
Occupation: ____

********Please answer the following questions********			
VACCINE HISTORY			
Have you ever had a COVID-19 Vaccine?	No	Yes	
Have you ever had a reaction after receiving a vaccine? If yes, describe:	No	Yes	
Have you received ANY vaccine(s) in the past 14 days?	No	yes	Type
ALLERGIES			
Are you allergic to anything that leads to breathing difficulties, rapid heart rate, rash/hives?	No	Yes	Name
Have you ever had an allergic reaction that required treatment with an EPIPEN or required hospitalization?	No	Yes	
Are you allergic to polyethylene glycol (PEG) or polysorbate?	No	Yes	Unsure
Health & Wellness			
Do you have weakened immune system caused by something such as HIV, cancer, or use of immunosuppressive therapies.	No	Yes	
Have you ever tested positive for or has a doctor told you that you had COVID-19?	No	Yes	Date
Have you received monoclonal antibodies or convalescent plasma for treatment of COVID-19	No	Yes	
Are you feeling sick today? (ex: cold, fever, or acute illness)	No	Yes	
Do you have dermal fillers?	No	Yes	
Do you have a bleeding disorder or take blood thinners?	No	Yes	
Women: Are you pregnant or breastfeeding?	No	Yes	
Which arm would you like to receive vaccine in today?	**Left**	**Right**	

By signing below, you acknowledge the following: The Food and Drug Administration has approved the vaccine being administered to you on an emergency use basis as a vaccination for SARS-CoV-2 (Coronavirus or COVID-19), after having found it to be safe and effective in accordance with Emergency Use Authorization requirements. Information about the vaccine has been made available to you in the form of the Emergency Use Authorization (EUA) Fact Sheet/VIS form. The vaccine being administered to you is not guaranteed to keep you from getting COVID-19. You may experience an adverse, even unexpected, reaction to it, including, without limitation, all or some of the signs and symptoms listed on the Vaccine Information Sheet. You are making an informed decision to receive the vaccine. You fully release and discharge Prosperity Drug Co, its affiliates and assigns, and its officers, and employees from any illness, injury, loss, or damage that may result from the administration of the vaccine. You also agree to wait in the vaccination area for 15-30 minutes for monitoring and to receive treatment in case of adverse reactions. Your insurance company will be billed for the administration of the vaccine and any additional services provided in the event of an adverse reaction. The vaccine is a single dose. Should you experience any symptoms, such as, without limitation, a fever of more than 101.5 F, fatigue, chills, headache, myalgia, or pain at the injection site, please contact your healthcare provider as soon as possible. If it is an emergency, please go to your nearest emergency medical provider if it can be done safely or contact 9-1-1.
I acknowledge that I have had an opportunity to read, understand and ask questions about the vaccine and the COVID-19 Vaccine Emergency Use Authorization (EUA) Fact Sheets/VIS relating to the vaccine I will be receiving and I accept all risks associated with such. I authorize Prosperity Drug Co. to release all information necessary to process my claims and provide the services above.

Signature of Patient: ____ **Date:** __________________

PHARMACY USE ONLY
Janssen COVID-19 Vaccine
Dose: 0.5ml

Site: Left Delt / Right Delt
Monitor: 15min / 30min
Administered by: MM(12640) / CRM(11465) / LMK(11418/Other:

Signature:____Date:_____________________

Profile
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