

COVID-19 Vaccine Administration Record (VAR) Informed Consent

PATIENT INFORMATION				
First Name:	Last Name:	DOB:	Age:	SSN:
Home Address:		City:	State:	Zip:
Phone:		Insurance: Private / Medicare Part B / None Medicare # (Red, White, & Blue 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				

SCREENING QUESTIONS			
1. Are you feeling sick today?	Yes	No	Unsure
2. Have you ever received a dose of COVID-19 vaccine? a. If yes, which vaccine product did you receive? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen	Yes	No	Unsure
3. Have you ever had an allergic reaction to a component of COVID-19 vaccine, including: <i>(This would include a severe reaction (e.g., anaphylaxis) that required treatment with an EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)</i> a. Polyethylene glycol (PEG) which is found in some medications, such as laxatives & colonoscopy preparations b. Polysorbate which is found in some vaccines, film coated tablets, and intravenous steroids	Yes	No	Unsure
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19) or an injectable medication?	Yes	No	Unsure
5. Check all that apply to you: <input type="checkbox"/> History of myocarditis or pericarditis <input type="checkbox"/> Severe allergic reaction to something other than a vaccine or injectable therapy, such as food, pet, venom, environmental, or oral medications <input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum <input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection <input type="checkbox"/> Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies <ul style="list-style-type: none"> • If yes, please initial here: _____ <input type="checkbox"/> Have a bleeding disorder <input type="checkbox"/> Take a blood thinner <input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT) <input type="checkbox"/> Currently pregnant or breast feeding <input type="checkbox"/> Have received dermal fillers <input type="checkbox"/> History of Guillain-Barré Syndrome (GBS)			

AUTHORIZATION / SIGNATURE	
<p>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.</p> <p>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.</p>	
Signature (patient or legal representative): _____	Date: _____

FOR PHARMACY USE ONLY	
COVID-19 (EUA 8/2021) • Pfizer • 0.3 mL • IM (Left / Right) Lot #: _____ Expiration: _____	Administered by: <input type="checkbox"/> Dana Crawford (42645) <input type="checkbox"/> Megan Montgomery (12640) <input type="checkbox"/> Carmen Monts (11465) <input type="checkbox"/> Leanne Kyzer (11418) <input type="checkbox"/> Michal Ann Robinson (43030) <input type="checkbox"/> Other _____ Signature: _____ Date: _____