COVID-19 Vaccine Consent Form

PERSONAL INFORATIND ABOUT INDIVIDUAL TO RECEIVE VACCINE					
Last Name		First Name		M.I.	Gender (circle) Male Female
Date of Birth	Age	Social Security #	Telephone Number		Alternate Number
Street Address			Apt. Number		
City	County		State		Zip Code

INSURANCE INFORMATION			
Name of Insurance Company	Member ID Number/Contract Number	Group Number	Relationship to Subscriber (select) ☐ Self ☐ Spouse ☐ Other ____
Subscriber Name (if different than patient)	Subscriber Birthdate	Subscriber Street Address, City, State, and Zip Code	
Secondary Insurance	Member ID /Contract Number	Group Number	Subscriber Name

In the event of an emergency, please provide:		
Emergency Contact	Relationship	Telephone Number

PLEASE SELECT ALL THAT APPLY TO INDIVIDUAL GETTING VACCINATION:

Healthcare Worker:
- __Inpatient
- __Outpatient
- __Long term Care Facility
- __Home Health/Hospice
- __Other HCW:
- __Laboratory

__ Emergency Medical Services
__Mortuary Services Provider

First Responder:
- __Law Enforcement
- __Fire Services
- __Correction Officer
- __Other:

- __Live or work in congregate or group setting (Group Home, Shelter, Correctional Facility
- __*Condition that puts one at high risk of severe illness or death from COVID-19
- __Work (paid/unpaid) in a K-12 school -educators, administrators, bus drivers, support staff
- __Work in one of the following: Food and Agriculture, Transportation and Logistics, Manufacturing, Public Safety, Food Service, Energy, Water and Waste Management, Legal, Media, Finance, Public Health
- __ Age 65 and older
- __ None of the categories apply to the individual getting vaccinated

*Cancer, Chronic Kidney Disease, COPD, Heart conditions, Immunocompromised, Obesity and Severe Obesity, Pregnancy, Sickle Cell Disease, Smoking, Type 2 Diabetes, Asthma, Cardiovascular Disease, Cystic Fibrosis, High Blood Pressure, Neurologic conditions such as dementia, Liver Disease, Overweight, Pulmonary Fibrosis, Type 1 Diabetes Mellitus

VACCINATION AND HEALTH-RELATED NFORMATION: If you answer Yes to questions 1 - 4, consult a health care provider.	YES	NO
1. Does the patient have long-term health problems with: immunocompromised condition or taking a medicine that affects your immune system; heart disease; lung disease; asthma; kidney or liver disease; metabolic disease such as diabetes; bleeding disorder or take blood thinner		
2. Has the patient had life-threatening reaction to any injectable medication, COVID-19 vaccine, or to a vaccine component (example eggs, thimerosal, gelatin, neomycin, phenol, or bovine protein? Yes, list:		
3. For Women: Are you pregnant or considering becoming pregnant in the next three months or currently nursing? If male, circle: NA		
4. Has the patient had a seizure or any other brain or other nervous system problem (i.e., Guillain-Barre Syndrome) after receiving vaccine?		
Has the patient ever received COVID-19 vaccination? If yes, date given:__________ Manufacturer:		

I have read or have had explained to me the information in the Vaccine Fact Sheet or Vaccine Information Sheet (VIS) about the Vaccine and a EUA Fact Sheet or VIS has been proided to me. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of requested Vaccine and ask that the Vaccine be given to me. I have reviewed the notice of my privacy rights and am aware that Rock Creek Pharmacy has their privacy practices posted in store. I understand that I can request a copy of these practices. I understand my infoma-tion and Vaccine(s) I receive will be entered into the Alabama Department of Public Health Immunization Registry. I give my permission for my insur-ance company to be billed and authorize payment directly to Rock Creek Pharmacy. I waive and release all claims I, or anyone claiming by or throug me, now have or may hereafter acquire against Rock Creek Pharmacy, and their respective owners, officers, employees, and agents for any damage or injuries if I, or the person named above for whom I am authorized to make this request, contract the illness prevented by the Vaccine, other diseas-es, or suffer any other adverse reactions following administration of this vaccine.

Signature of Individual/Parent/Legal Guardian ____________________ Date ____________

For Clinic Use Only

Clinic Site	Date Vaccine and VIS/Fact Sheet Given			Type and Date of VIS or EUA Fact Sheet		JCDH Patient	
Rock Creek Pharmacy				Moderna EUA		Yes	No
Vaccine Given __Moderna 1st Dose __Moderna 2nd Dose	Manufacturer Moderna	Lot # 013M20A	NDC # 80777-273-99	Exp. Date 07/31/2021	Injection Site LA RA	Route IM	Dose 0.5 ml
Nurse Signature					Date		

Notes: