Giant/Martins Pharmacy COVID-19 Vaccine Informed Consent

First Name:	Middle Name:	Last Name:	Date of Birth: _____ Age:_____Gender:_____

Address: _____City:_____County:_____State:_____Zip:_____

Email Address: _____ Home Phone: _____ Mobile Phone: _____

Primary Care Provider: _____ Provider Phone Number: _____

Provider Address: _____ I do not currently have a Primary Care Provider □

I would like a copy of this consent □

Indicate your race by choosing one of the following options:

□ Asian □ Black/African American □ White □ Other

□ Native Hawaiian/Other Pacific Islander □ Unknown

□ American Indian/Alaskan Native

Indicate your ethnicity by choosing one of the following options:

□ Hispanic or Latino □ Not Hispanic or Latino

□ Unknown

Do you have a red/white/blue Medicare card? Yes □ No □		Billing Information (complete if uninsured)	
Medicare B Number		Last 4 SSN	
Name as it appears on card		ID Info	ID #: State:

Screening Questionnaire. Ask or contact the pharmacist for any assistance.	Yes	No
Do you feel sick today? (For example: a cold, fever, or acute illness)		
Have you ever received a dose of COVID-19 vaccine before? Product: _____ Date: _____		
Have you ever had an allergic reaction to any of the following? • Polysorbate • 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 • A previous dose of COVID-19 vaccine *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen®. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)*		
Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? *(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.)*		
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, 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 doctor ever told you that you had COVID-19?		
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? When was your last dose? _____		
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?		
Are you pregnant, planning to become pregnant, or breastfeeding?		

Pharmacist Use Only Section

Admin Date	Dose #	Lot	EXP Date	Manufacturer	Dose	Injection Site	EUA Revised Date	EUA Provided Date
					mL	IM L / R Deltoid		

Copy sent to provider: YES □ NO □ Certificate of Immunization given to patient: YES □ NO □

Registry checked to confirm COVID dose number/product: YES □ NO □ Date: _____ Product: _____

I have reviewed the Vaccine Screening Questionnaire to assess the patient for potential contraindications and precautions to the vaccines being administered today. I have confirmed vaccine requested is indicated for the patient. RPh Initials: _____

Pharmacist/Intern/Technician Name: _____ Title: _____ Date: _____

Pharmacist/Intern/Technician Signature: _____ NPI: _____

Location of Pharmacy/Administration: _____ Phone: _____

Dose #2 Date: _____ Dose #2 Time: _____

Informed Consent:

Emergency Use Authorization: The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same time of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Consent: I have been provided and have read, or had explained to me, the patient fact sheet corresponding to the COVID-19 vaccination given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand that if this vaccine requires 2 doses, 2 doses of this vaccine will need to be administered (given) in order for it to be effective. I have been given the opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risk of the vaccination, and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for at least 15 minutes and may need to remain for 30 minutes (if required based on answers to screening questions above) after the vaccination to be monitored for potential adverse reactions. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, or call 911. I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand that any monies or benefits for administration the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I understand that GIANT/MARTINS PHARMACY may be required to or may voluntarily disclose my health information to my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment, or other health care operations (such as administration or quality assurance). I also understand that GIANT/MARTINS PHARMACY will use and disclose my health information as set forth in the Notice of Privacy Practices (copy is available in-store, online, or by requesting a paper copy from the pharmacy).

Patient Name (Printed): _____

X_____ Date: _____

Signature of Patient or Patient's Personal Representative **A Personal Representative is someone who has legal authority to make healthcare decisions on the behalf of the patient*

Patient Guardian (please print): _____ Guardian Type: _____

Additional Vaccine Administration Screening Questionnaire/Customer Information During COVID-19 Community Transmission

To help protect customers and associates during any period of declared COVID-19 community transmission, we are asking that all customers complete the following additional screening questions prior to being evaluated for vaccination need and administration.

We require customers to wear a face mask (*at minimum a disposable, ear loop surgical mask*) during the entirety of the vaccination process during any period of declared COVID-19 community transmission. If you do not have an appropriate face mask, one will be provided to you at no charge. If you have any condition that prevents you from wearing a mask, please alert the pharmacist and discuss deferring the vaccine administration until a time when there is no community transmission of COVID-19.

Patient Name: _____ Date of Birth: _____

Please answer the following questions	**Yes**	**No**
1) Within the past 24 hours, have you experienced fever without the use of fever-reducing medication?		
2) Are you currently experiencing any of the following symptoms? • Cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea		
3) If you have recently experienced any of the above symptoms, have they gotten worse/remained the same, and has it been less than 10 days since they first appeared?		
4) In the past 14 days, have you had close contact with any person with confirmed or suspected active COVID-19 infection?		
5) Have you received a COVID-19 Vaccination in the last 14 days?		
6) Do you have a confirmed appointment to receive a covid-19 vaccination in the next 14 days?		