COVID-19 Vaccine Administration Record – Informed Consent

LAST NAME	FIRST NAME:	(M.I.)	DATE OF BIRTH:	
ADDRESS:			AGE:	GENDER: M / F
			RACE:	PHONE NO:
CITY:	STATE:	ZIP CODE:	ETHNICITY:	

For Vaccine Recipients: The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "yes" to any question, It doesn't necessarily mean you shouldn't be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

COVID-19 VACCINE	YES	NO	DON'T KNOW
1. Do you feel sick today?	☐	☐	☐
2. Have you ever received a dose of Covid-19 vaccine?	☐	☐	☐
a. If yes, Which vaccine product? ☐ Moderna ☐ Pfizer ☐ Johnson Johnson (Jenssen)			
3. Do you have allergies or reactions to medications, foods or any vaccine? (For example: eggs, gelatin, neomycin, Thimerosal, latex, etc.) If yes, Please list:	☐	☐	☐
a. Was the severe allergic reaction after receiving a COVID-19 vaccine?	☐	☐	☐
b. Was the severe allergic reaction after receiving another vaccine or another injectable medication?	☐	☐	☐
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
5. Have you received another vaccine in the last 14 days?	☐	☐	☐
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
7. Do you have weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
8. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
9. Are you pregnant or breastfeeding?	☐	☐	☐

Insured Patient only

	Pharmacy Card	Medical Card
Insurance Plan		
Member ID		
Group No		NA
RX BIN		NA
RX PCN		

Medicare Patient only

Medicare No	

Uninsured Patient only

Drivers License / State ID		Issuing State	
Social Security Number (If applicable)			

Please read the following statements and sign on the signature line below

I have been provided with the Vaccine Information Sheet corresponding to the vaccine(s) that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I voluntarily authorize and direct my health care provider at Auro pharmacy to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at Auro pharmacy, my Primary Care Physician (PCP), my insurance plan and/or state or federal registries, where required, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). This authorization permits Auro pharmacy to disclose the following medical records: only documents related to the vaccination(s) received today. This Authorization will remain in effect until my health care provider discloses my health information to the recipient identified above; my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such a refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.I acknowledge that I have received the Auro pharmacy Notice of Privacy Practices, which is provided on the back of the patient copy of this consent form.

Patient Signature: _____ **Date:** _____

(Parent or guardian if minor)

To be completed by the Pharmacy:

Please complete after vaccine administration only:

Date: _____ Product: _____ Manufacturer: _____ Volume (mL): _____

Route: _____ Site: _____Lot No.: _____ Expiry Date: _____

Immunizer Name & Title: _____