IMMUNIZATION SCREENING AND CONSENT FORM

PATIENT INFORMATION

Last Name:	**First Name:**	**MI:**	**DOB:**	**Age:**	**Gender:**
Home Address:			**Contact Phone:**		
City:	**State:**	**Zip Code:**	**County:**		
Race (*select one or more*): **__American Indian or Alaska Native** **__Asian** **__Black or African American** **__Native Hawaiian or Other Pacific Islander** **__White** **__Other**			**Ethnicity:** **__Hispanic or Latino** **__Not Hispanic or Latino**		
Primary Care Physician:			**Physician Phone:**		

SCREENING QUESTIONNAIRE

ALL VACCINES	**YES**	**NO**	**DON'T KNOW**
Are you feeling sick or experiencing a moderate to high fever today?	☐	☐	☐
Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product did you receive? ○ Pfizer ○ Moderna ○ Other _____	☐	☐	☐
Have you ever had an allergic reaction to any of the following: (*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)* .1) 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, 2) Polysorbate, or 3) a previous dose of COVID-19 vaccine	☐	☐	☐
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?	☐	☐	☐
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/	☐	☐	☐
For women: Are you pregnant or considering becoming pregnant in the next month?	☐	☐	☐

I certify that I am: (a) the patient and at least 18 year of age or (b) the parent or legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of The Medicine Store, as applicable (each an applicable provider) to administer the COVID-19 vaccine. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read, and/or had explained to me the EUA (Emergency Use Authorization) Fact sheet on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that questions were answered to my satisfaction. On behalf of myself, my heirs, and directors, I release The Medicine Store contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above.

I voluntarily authorize and direct my healthcare provider at The Medicine Store to use or disclose my health information during the term of this Authorization to my Primary Care Physician, my insurance and/or state or federal registries, where required, for the purpose of treatment, payment, or other healthcare operations

PATIENT NAME: _____ **DATE OF BIRTH:**_____
(*PLEASE PRINT CLEARLY*)

PATIENT SIGNATURE: _____ **DATE:** _____