2021 COVID-19 Vaccine Consent

Name: ______________________

Address: ______________________

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Email: ______________________

Phone: ______________________

Date of Birth: ______________________

A record of this immunization may be released to your physician as required by state law.

Affix Prescription Label Here
Vaccine Name: (Circle) Pfizer – Moderna – AstroZenica Lot #: ____________ Exp.: ____________ Arm Administered: LEFT RIGHT EUA Patient Info Given to Patient: YES

Question		
Have you previously received the COVID-19 vaccine?	YES	NO
Have you had a severe allergic reaction after receiving the COVID-19 Vaccine?	YES	NO
Have you ever had a reaction to any component or ingredient of the COVID-19 vaccine?	YES	NO
Have you ever had a severe allergic reaction to any other vaccine or injection?	YES	NO
Do you have a bleeding disorder or are you taking a blood thinner?	YES	NO
Are you immunocompromised?	YES	NO
Do you have a fever?	YES	NO
Are you feeling sick?	YES	NO
Are you pregnant?	YES	NO
Could you become pregnant in the next several weeks?	YES	NO
Are you breastfeeding (nursing)?	YES	NO

I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid, or other third party payer as needed and request payment of authorized benefits be made on my behalf to Fruth Pharmacy, Inc.

- • I confirm the information is accurate.
- • I acknowledge that if my insurance does not cover the cost of administering the vaccine to the pharmacy, that payment must be made at the time of administration of the vaccine.
- • I acknowledge that my vaccination records may be shared with federal, state, or local agencies for registry reporting.
- • I acknowledge that patients should remain in the waiting area for 30 minutes post administration.
- • I acknowledge receipt of Fruth Pharmacy's Notice of Privacy Practices for Protected Health Information.
- • I acknowledge that the administration of an immunization/vaccine does not substitute for an annual check-up with primary care physician.
- • I have read, or have had read to me the EUA Fact Sheet(s) for COVID-19 administration. I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s). I fully release and discharge Fruth Pharmacy, Inc., its affiliates, officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from.

Signature: ______________________

Date: ______________________