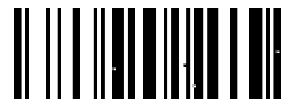
Informed Consent for the COVID-19 Vaccination Series



SECTION A ***Information About Individual to Receive the COVID-19 Vaccination Series (please print clearly)***

Vaccine Recipient Information ☐ Resident ☐ Facility Staff ☐ Other

First name: ______________________________ M.I.: _______ Last Name: ____

Date of birth: ______________________________ Age: _______ Gender: ☐ Female ☐ Male Phone: ______________________

Home address: ____ City: ____________________ State: ______ Zip Code: _________

Facility Name:____ County: ____

Power of Attorney (POA)/Legal Guardian Information *(if applicable)*

First name: ______________________________ M.I.: _______ Last Name**:** ____

Primary Care Provider Information

☐ My Primary Care Provider is the facility's medical director. Medical Director's Name: _______________________________

☐ I have an established relationship with a Primary Care Provider. Primary Care Provider's Name: ___________________________

☐ I do not have a Primary Care Provider.

Billing Information *Provide copies of insurance cards (if applicable)* ☐ NO Insurance *(*If no insurance, please still provide SSN or DL information)*

☐ Medicare Medicare Number: ________________________ *Social Security or Driver's License Number: __________________

☐ Rx Insurance Plan Name: ________________________ ID Number: ____

Group: _________________ BIN: ______________________ PCN: ______________________

SECTION B ***Screening for Vaccine Eligibility***

1.	Have you been vaccinated with the COVID-19 vaccine? If yes, complete the information below. Vaccine Brand (i.e. Pfizer, Moderna,etc.):____ Date Dose #1 Given *(Month/Day/Year)*:___________ Date Dose #2 Given *(Month/Day/Year)*:___________	☐ Yes ☐ No ☐ Don't know
2.	In the past two weeks, have you received any other vaccine(s)?	☐ Yes ☐ No ☐ Don't know
3.	Do you feel sick today?	☐ Yes ☐ No ☐ Don't know
4.	Have you received monoclonal antibody treatment in the past 90 days?	☐ Yes ☐ No ☐ Don't know
5.	Do you have allergies to latex, oral or injectable medications, food, or vaccines? (If yes, list your allergies): ____ ____	☐ Yes ☐ No ☐ Don't know
6.	Have you ever had a severe allergic reaction (i.e. anaphylaxis) after receiving a vaccination or injectable therapy?	☐ Yes ☐ No ☐ Don't know
7.	For women: Are you pregnant, possibly pregnant, or considering becoming pregnant in the next month?	☐ Yes ☐ No ☐ Don't know

SECTION C ***Consent***

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to Absolute Pharmacy and the licensed healthcare professional administering the vaccine, 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 the COVID-19 vaccine. I understand the risks and benefits associated with the COVID-19 vaccine and have received, read and/or had explained to me the Vaccine Information Statement and/or the Emergency Use Authorization fact sheet. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for observation for the time specified by the applicable Provider after administration. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, 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 COVID-19 vaccine.

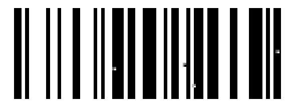
☐ **I GIVE CONSENT** to the applicable Provider for the individual named in Section A to be vaccinated with the COVID-19 vaccine.

☐ **I DO NOT GIVE CONSENT** to the applicable Provider for the individual named in Section A to be vaccinated.

Individual Signature, Signature of POA, or Printed Name of POA/verbally acknowledged by licensed facility staff (*sign/print name and credentials):*

X ____ **Date:** ________________

Vaccine Administration Record - COVID-19 Vaccination Series



Vaccine Recipient Information

☐ Resident ☐ Facility Staff ☐ Other

First name: ______________________________ M.I.: _______ Last Name: ____

HEALTHCARE PROVIDER USE ONLY BELOW THIS LINE

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Clinic/Pharmacy Name: Absolute Pharmacy
Address: 7167 Keck Park Circle, North Canton, OH 44720
NPI: 1396719076

SECTION D ***Complete DURING Vaccine Administration – Dose 1***

1. I have reviewed the **Vaccine Recipient Information** and **Screening Questions** with the patient. Initial here: __________
2. I have verified whether the person is a **resident or staff member** of the facility. Initial here: __________
3. I have verified the **Vaccine NDC** matches the NDC on the bottom of this VAR. Initial here: __________
4. I have provided the patient with the **Emergency Use Authorization Fact Sheet** or **Vaccine Information Statement** and **counseling**, as applicable. Initial here: __________
5. I have provided the patient with a completed **COVID-19 Vaccination Record Card**. Initial here: __________
6. I have reminded the patient of the **need for a second dose** and the timeframe in which to receive it. Initial here: __________

Vaccine Information & Dose/Route Given: ☐ Pfizer COVID-19 NDC: 59267-1025-01 0.3 mL/IM ☐ Moderna COVID-19 NDC: 80777-0273-10 0.5 mL/IM ☐ Other ____	**Lot:** **Expiration:**
	Injection Site: L Arm R Arm **Needle Gauge/Length:** 25G 1in 25G 5/8 in Other: __________
Vaccine Administrator Printed Name/Title:	**Vaccine Administrator Signature:**
Notes:	**Date Administered:**

After vaccine administration, fax the completed Vaccine Administration Record (VAR) to Absolute Pharmacy (1-800-858-7394).

SECTION E ***Complete DURING Vaccine Administration – Dose 2***

1. I have reviewed the **Vaccine Recipient Information** and **Screening Questions** with the patient. Initial here: __________
2. I have verified whether the person is a **resident or staff member** of the facility. Initial here: __________
3. I have verified the **Vaccine NDC** matches the NDC on the bottom of this VAR. Initial here: __________
4. I have provided the patient with the **Emergency Use Authorization Fact Sheet** or **Vaccine Information Statement**, as applicable Initial here: __________
5. I have provided the patient with a completed **COVID-19 Vaccination Record Card**. Initial here: __________

Vaccine Information & Dose/Route Given: ☐ Pfizer COVID-19 NDC: 59267-1025-01 0.3 mL/IM ☐ Moderna COVID-19 NDC: 80777-0273-10 0.5 mL/IM ☐ Other ____	**Lot:** **Expiration:**
	Injection Site: L Arm R Arm **Needle Gauge/Length:** 25G 1in 25G 5/8 in Other: __________
Vaccine Administrator Printed Name/Title:	**Vaccine Administrator Signature:**
Notes:	**Date Administered:**

After vaccine administration, fax the completed Vaccine Administration Record (VAR) to Absolute Pharmacy (1-800-858-7394).

THIS DOCUMENT MUST BE MAINTAINED FOR THREE (3) YEARS FROM THE ADMINISTRATION DATE