Please Print Information Clearly

Side 1 of 2 to be completed

COVID Vaccine Consent Form

Clinic Information

PA SIIS Clinic #_____ Care Options Rx 800-266-9954 219 N. Baltimore Ave, Mt Holly Springs PA 17065

Patient Information

Last Name	First Name		Date of Birth	Phone #

Address	City	State	Zip	SSN

Primary Care Provider (PCP) Name	PCP Phone Number	PCP Fax Number

PCP Address	City	State	Zip

Did patient refuse to provide the requested information above? If yes, reason: _____

If you are a part of a Long-Term Care community, are you a ○ resident or an ○ employee/staff?

If someone else manages health decisions on behalf of the resident, please provide the following:

Caregiver/Financially Responsible Party Name	Relationship	Phone #

Insurance Information:

Please provide copies of the front and back of your insurance cards, both medical and pharmacy.

Is the patient aged 65 or older and eligible for Medicare? ○ Yes ○ No If yes: Medicare #_____

Insurance ID:	Rx BIN#	Rx Grp#	Rx PCN:

If you are uninsured, please read the below statement and check the box for acknowledgement:

○ I do not have medical insurance, Medicare, Medicaid or any commercial or government-funded health benefit plan. I acknowledge that I must answer this question truthfully in order to have the cost of my vaccine/administration fee covered by the US Department of Health and Human Services (HHS) Uninsured Program. If I have active insurance that I fail to provide, I may be charged in full for the vaccine.

Immunization Screening Questions

		Yes	No	Don't Know
1.	Do you have allergies or reactions to any foods, medications, vaccines, or latex? (for example: eggs, gelatin, neomycin, thimerosal, etc.)	○	○	○
2.	Have you ever had a serious reaction after receiving a vaccination? Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	○	○	○
3.	Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	○	○	○
4.	Do you take anticoagulation medication? For example: warfarin, Coumadin, or other blood thinners.	○	○	○
5.	Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?	○	○	○
6.	Do you have cancer, leukemia, HIV?AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease or any other immune system problem?	○	○	○
7.	Do you have a weakened immune system or in the past 3 months, taken medications that weaken it, such as cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments?	○	○	○
8.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	○	○	○
9.	For Women, are you pregnant or is there a chance you could become pregnant in the next month?	○	○	○
10.	Have you received any vaccinations or TB skin tests in the past 4 weeks?	○	○	○

Please Print Information Clearly

Side 2 of 2 to be completed

Last Name	First Name	Date of Birth

Consent for Services: I have been provided with the Vaccine Information Sheet(s) corresponding to the vaccine(s) that I am receiving. I have read 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 understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

Authorization to Request Payment: I do hereby authorize Care Options Rx (CORx) to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

Disclosure of Records: I understand the CORx may be required to or may voluntarily disclose my health information to the physician responsible for the immunization protocol for people vaccinated by CORx staff (if applicable), 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 CORx will use and disclose my information as set forth in the CORx Notice of Privacy Practices (copy is available in pharmacy, or by requesting a paper copy from the pharmacy). Vaccine Clinics: If I am receiving a vaccine through a vaccine clinic, I understand that my name, vaccine appointment date and time will be provided to the clinic coordinator at my community and CORx.

X

Signature of Patient to receive vaccine or person authorized to make the request Date

Did you provide copies of the most up to date insurance information to Care Options Rx?
If not, please forward copies to them. Fax: 800-266-9947, Attn: Vaccine Coordinator

Day of Clinic- Pharmacy Use Only

COVID-19 Screening Questions		Yes	No	Don't Know
1.	Are you sick today? (for example: a cold, fever or acute illness)	○	○	○
2.	In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?			
3.	In the past two weeks, have you had contact with anyone who tested positive for COVID-19?	○	○	○
4.	Do you currently or have you in the past 14 days, had a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?	○	○	○

Patient Temperature at time of clinic: **Date:**

If patient answers yes to any of these questions or patient's bodily temperature is 100°F or greater, they should not receive the vaccine at the current time. The patient should contact their PCP for further instructions and the community coordinator will be notified.

Vaccine Administration Information

Administration Date	Vaccine	VIS Date	Manufacturer

Lot #	Exp. Date	Route	Site	Volume (mL)

X

Administering Immunizer Name and Title Administering Immunizer Signature