Mt. Holly Pharmacy
Free Delivery • Medical Supplies • Specialty Rxs
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COVID Vaccine Consent Form

Patient Information

**Are you 18 years or old Yes __ No __

Last Name | First Name | Date of Birth | Age | Gender

Address | City | State | Zip

Cell Phone | Home Phone

Race: 1 - American Indian or Alaska Native | 2 - Asian | 3 - Native Hawaiian/Other Pacific Islander | 4 - Black or African American | 5 - White | 6 - Other Race

Ethnicity: 1 - Hispanic | 2 - Not Hispanic or Latino | 3 - Unknown

Primary Care Provider (PCP) Name | PCP Phone Number

Please select one below:

Is this the patient's First ____ or Second_____dose of the COVID-19 vaccine?

Prescription Insurance:

*Are you the primary cardholder? Yes / No | *If no, include the primary cardholder's DOB

*Prescription Benefit Plan Name | *Cardholder ID # | *RX Group ID | *BIN | *PCN

Medicare Fields:

○ Yes ○ No

*Is the Patient age 65 or older or Medicare Eligible?

*Medicare Part A/B ID Number (MBI) **Note:** *MBI is required for all patients age 65 and older, or Medicare eligible. Refer to your Medicare Red, White, and Blue card*

***If uninsured, you must check the box below to attest that the following information is true and accurate:**

○ I I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government-funded health benefit plan.

In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, please provide either (a) a valid Social Security number, (b) state identification number and state of issuance, OR (c) a driver's license number and the state of issuance.

*Social Security Number | or State Identification Number & State | or Driver's License Number & State

Potential Contraindications	YES	NO	DON'T KNOW
1. Are you feeling sick today?	○	○	○
2. Have you ever received a dose of COVID-19 vaccine? **If yes**, which vaccine product? ○ Pfizer ○ Moderna ○ Another product: _____	○	○	○
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) in the past? *Example: a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?*	○	○	○
Was the severe allergic reaction after receiving a COVID-19 vaccine?	○	○	○
Was the severe allergic reaction after receiving another vaccine or injectable medication?	○	○	○
Was the severe allergic reaction related to receiving Polyethylene Glycol or products containing Polyethylene Glycol?	○	○	○
Was the severe allergic reaction related to receiving Polysorbate or products containing Polysorbate?	○	○	○

Form 2 of 2 to be completed

Last Name	First Name	Date of Birth

Potential Contraindications continued	YES	NO	DON'T KNOW
4. Have you received any vaccines in the past 14 days?	○	○	○
5. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days?	○	○	○

Potential Considerations	YES	NO	DON'T KNOW
6. Do you have a bleeding disorder or are you taking a blood thinner?	○	○	○
7. For women, are you currently pregnant or breastfeeding?	○	○	○

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet(s) or patient fact sheet 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 Express Discount Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid, or the HRSA COVID-19 Program for Uninsured Patients, 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 that Express Discount Pharmacy may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at Express Discount Pharmacy (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 Express Discount Pharmacy will use and disclose my health information as set forth in the Notice of Privacy Practices (copy is available in-store)
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.

Dose 1

X

Signature of patient to receive vaccine (or parent, guardian, or authorized representative) Date

If signing on behalf of the patient, you are stating that you are authorized to provide the required consents on behalf of the patient.

Name of parent, guardian, or authorized representative | Phone Number | Relationship

DOSE 2

X

Signature of patient to receive vaccine (or parent, guardian, or authorized representative) Date

If signing on behalf of the patient, you are stating that you are authorized to provide the required consents on behalf of the patient.

Name of parent, guardian, or authorized representative | Phone Number | Relationship

FOR PHARMACY USE ONLY

VACCINE	DATE	SITE/ROUTE	MANUF./LOT NO	VIS DATE	DATE VIS GIVEN
COVID-19 (1st dose)				12/20/20	
COVID-19 (2nd dose)				12/20/20	

Vaccine Administered By _____