POOLER PHARMACY COVID-19 Vaccine Consent Form

NAME (Last)		(First)	**DATE OF BIRTH**	**GENDER**
ADDRESS				
CITY	**STATE**	**ZIP**	**DAYTIME PHONE NUMBER**	
PRIMARY CARE PHYSICIAN:	**Name**	**Address**	**Phone Number**	
EMERGENCY CONTACT:	**Name**	**Relation**	**Phone Number**	

IS THIS YOUR FIRST ___ OR SECOND ___ DOSE OF THE COVID-19 VACCINE? If this is your second dose, what was the date of your first dose?

	YES	**NO**
1. Do you have any allergies? Please list:		
2. Are you sick today? (For example, cold, fever, or acute illness)		
3. Do you have a bleeding disorder or are you on a blood thinner?		
4. Are you immunocompromised or are you on a medicine that affects your immune system?		
5. Are you pregnant or plan to become pregnant?		
6. Are you breastfeeding?		
7. Have you received another COVID-19 vaccine other than your 1st dose?		
8. Are you 55 years old or older, an adult with intellectual or developmental disability, parent of child with complex medical condition, or their caregiver, or over the age of 16 with high-risk condition ?		
9.Are you a healthcare worker, law enforcement, first responder, educator, or long-term care resident/employee:		
10.Current pharmacy:		

_____ I have been given a copy and have read, or have had explained to me, the information in the FACT SHEET for the COVID-19 vaccine. I understand the FDA has authorized the emergency use of the COVID- 19 vaccine, which is not an FDA-approved vaccine. I have had the chance to ask questions that were answered to my satisfaction.

_____ I understand some COVID-19 vaccine requires 2 doses given 3 to 4 weeks apart. If this is my first dose of the COVID-19 vaccine(Pfizer or Moderna), I intend to receive a second dose of the same vaccine in accordance with the time frame specified in the Fact Sheet to complete the vaccination series.

_____ I understand the significant known and potential risks and benefits of the COVID-19 vaccine as explained in the FACT SHEET and that some potential risks and benefits may remain unknown, and I REQUEST THE COVID-19 VACCINE BE GIVEN TO ME.

I agree to stay in the vaccine administration area for fifteen (15) minutes (or longer if indicated by the vaccine administrator) after receiving my vaccination to ensure that no immediate adverse reactions occur, and I understand that if I experience any adverse reaction, it will be my responsibility to follow up with my primary care physician.

SIGNATURE OF PATIENT / EMPLOYEE / LEGAL REPRESENTATIVE:

_____DATE:_____

RELATIONSHIP TO PATIENT (if applicable)

_____

Vaccine	**Dose**	**Route**	**Date Dose Administered**	**Vaccine Manufacturer**	**Lot Number**	**Expiration Date**	**Name of Vaccine Administrator**
COVID-19	_____ml ϒ 1st _____ml ϒ 2nd	IM - L Arm IM - R Arm		J& J, Moderna, Pfizer			Pooler Pharmacy