Email

County

COVID Vaccine Intake/Consent Forms

Vaccine: Pfizer Moderna J&J

Date of Vaccination#1___________

Date of Vaccination#2___________

Patient Information:

Age of patient_____________

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

Address | City | State | Zip | Phone

Person Filling Out this Form:	Patient Demographics continued:
☐ Myself *(skip to Insurance Information below)*	Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other ☐ Prefer Not to Say
☐ Person responsible for health/financial decisions *(complete Caregiver information below)*	Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Prefer Not to Say

Caregiver/Financially Responsible Party Name | Relationship to Patient | Phone

Insurance Information: Fill in all that apply

Prescription Insurance Provider | RX ID# | Rx Group | RX BIN | RX PCN

Medical Insurance Provider | ID# | Group ID | Toll free number on back of card

Is patient primary cardholder? ☐ Yes ☐ No

☐ I do not have Medicare Part B

Medicare Part B (see example below): | Medicare Part A/B ID Number (MBI)

MEDICARE HEALTH INSURANCE Name/Nombre JOHN L SMITH Medicare Number/Número de Medicare 1EG4-TE5-MK72 Entitled to/Con derecho a: HOSPITAL (PART A) 03-01-2016; MEDICAL (PART B) 03-01-2016 Coverage starts/Cobertura empieza SAMPLE	The Social Security Administration has issued new Medicare Health Insurance cards with new ID numbers as of April 2019, the new Medicare ID Number includes a combination of letters and numbers. Please be sure to **provide us with a copy of the new card** in order to bill vaccine claims to Medicare at no cost to the patient. If the patient does not have a copy of the card, please contact the Social Security Administration at (800) 772-1213 for a replacement card.

Uninsured Information/Attestation:

If you are uninsured, please read the following statement and check the box to acknowledge:

☐ I do not have prescription/medical insurance or Medicare Part B. I request the cost of the vaccine and administration be submitted to the U.S. Department of Health and Human Services (HHS) Uninsured Program.

--Continue on side 2

COVID-19 Screening Questions:	YES	NO	DON'T KNOW
1. **In the past 2 weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?**	☐	☐	☐
2. **In the past 2 weeks, have you had contact with anyone who tested confirmed positive for COVID-19?**	☐	☐	☐
3. **In the past week have you had or do you have any of the known symptoms of COVID-19 (e.g. fever, chills, cough, shortness of breath, fatigue, body aches, headaches, loss of taste or smell, etc)?**	☐	☐	☐

Immunization Screening Questions:	YES	NO	DON'T KNOW
1. **Are you sick today or have you had a fever in the last 3 days?**	☐	☐	☐
2. **Have you had the flu vaccine or any vaccination before?**	☐	☐	☐
3. **Do you have allergies to medications, eggs, latex, any vaccine or vaccine component (e.g. thimerosol)? Allergy to polyethylene glycol (PEG) or polysorbate?**	☐	☐	☐
4. **Have you ever had a serious reaction after receiving a vaccination?**	☐	☐	☐
5. **Do you have cancer, leukemia, AIDS, or any other immune system problem?**	☐	☐	☐
6. **Do you take cortisone, prednisone, other steroids or anticancer drugs, or x-ray treatments?**	☐	☐	☐
7. **Have you received any vaccine in the last 14 days?**	☐	☐	☐
8. **Are you currently taking any blood thinning medications (e.g. coumadin/warfarin)?**	☐	☐	☐
9. ***For women*: Is it possible that you are pregnant or may become pregnant in the next month?**	☐	☐	☐
10. **Are you affected by any of the following health conditions :** Cancer, Chronic Kidney Disease, COPD, Heart Condition, Solid Organ Transplantation, Obesity or Severe Obesity, Sickle Cell Anemia, Type 2 Diabetes Mellitus.	☐	☐	☐

Consent for Vaccination: I have received the Vaccine Information Sheet (VIS) or equivalent EUA-Fact Sheet for the vaccine I am receiving. I have read the information and have had time to ask questions to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reaction(s) that may result. I understand that any side effects should be reported immediately to the pharmacist, doctor, and to call 911. I certify I was pre-screened for this vaccine and do not have any conditions that would prevent me from receiving this vaccine. For additional information, I can go to https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html I understand it is my responsibility to make sure I receive the second dose of the vaccine when it is due.

Authorization to Request Payment: I do hereby authorize Trinity Apothecary to release information and request payment. I certify that the information I supplied is correct and authorize payment of benefits be made on my behalf.

Disclosure of Records: I understand that Trinity Apothecary is required to report/disclose my information to governmental agencies involved in this vaccine program.

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

Vaccine Administration Information - for immunizer/Pharmacist use only

COVID-19 Vaccine - Pfizer Moderna J&J Other______________________

○ Dose 1 Date Given:_______________

Lot # _________________ Exp Date_______________ Site: L / R

○ Dose 2 Date Given:_______________

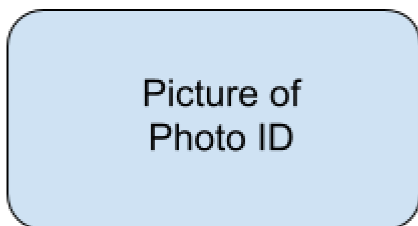
Lot # _________________ Exp Date_______________ Site: L / R

Signature: _____________________________________ Date: _______________

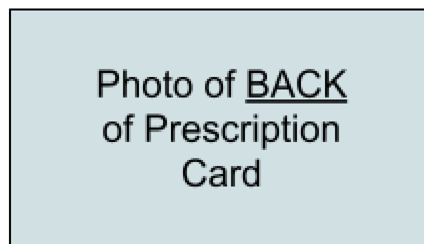
Photocopies of ID and Insurance Cards

In order to participate in the COVID-19 Vaccination Program, you will need to provide Trinity Apothecary the following information:

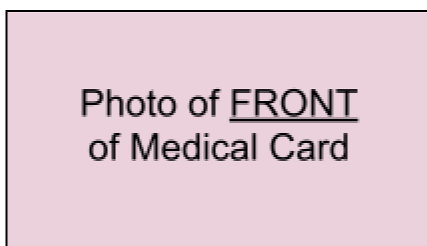
Photo ID (REQUIRED) (e.g. driver's license)

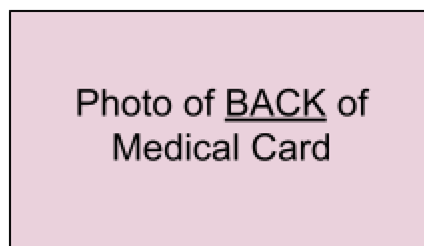


Prescription Insurance Card (if applicable)



Medical Insurance Card (if applicable)





Medicare A/B Card (if applicable)