Coastal Care Partners
HAVE A NURSE MANAGE YOUR CARE
MY NURSE NOW

COVID-19

Immunization Consent Form

Race_____ Ethnicity_____

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	MI	GENDER (M/F)
ADDRESS	CITY	STATE	ZIP
10-DIGIT PHONE NUMBER	MEDICARE ID NUMBER		BIRTH DATE (MM/DD/YY)
PRIMARY CARE PHYSICIAN	PRIMARY CARE PHYSICIAN ADDRESS	PRIMARY CARE PYSICIAN PHONE	COVID-19 VACCINE Dose 1 _____ Dose 2 _____

CASE HISTORY AND LISTED CONTRAINDICATIONS (Please circle YES, NO, or DON'T KNOW for each question)

COVID-19 VACCINE

1. Have you had a physical examination within the past year? YES NO DON'T KNOW
2. Are you sick today?.....YES NO DON'T KNOW
3. Do you have allergies to any medications, food, insect bites, latex, or a vaccine component?..... YES NO DON'T KNOW

If yes list allergies and reaction if known**_____
_____.
_____.

4. Have you ever had a serious reaction after receiving a vaccine? .....YES NO DON'T KNOW
5. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder? .....YES NO DON'T KNOW
6. Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?.....YES NO DON'T KNOW
7. Do you have a bleeding disorder or are you on a blood thinner? YES NO
8. Have you had a seizure, brain disorder, Guillian-Barre Syndrome or other nerve problem?.....YES NO DON'T KNOW
8. In the past 3 months, have you taken any medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?..... .....YES NO DON'T KNOW
9. During the past year, have you received a transfusion of blood or blood products, or been given a immune (gamma) globulin or an antiviral drug? .....YES NO DON'T KNOW
10. For women: Are you pregnant/breastfeeding or is there a chance you could pregnant during the next month? .....YES NO DON'T KNOW
11. Have you received any vaccinations in the past 14 days? .....YES NO DON'T KNOW
    If yes, what vaccines? _____
    _____
12. Have you had a positive test for COVID-19 or has a doctor ever told you that you have had COVID-19?.....YES NO DON'T KNOW
13. If you have had COVID-19 disease, have you received monoclonal antibody infusion or convalescent plasma in the last 90 days? YES NO DON'T KNOW

I certify that I am: (a) the patient and at least 18 years of age; or (b) the parent or legal guardian of the patient ('Ward'). I have received a copy of the FACT SHEET for COVID-19 vaccine and I have read the adverse reactions associated with the administration of COVID-19 vaccine. I understand the FDA has authorized the emergency use of the COVID-19 vaccine, which is not an FDA-approved vaccine. Furthermore, I consent to the administration of the COVID-19 vaccine requested above to me or my Ward and acknowledge that, as a condition to administration of the COVID-19 vaccine, myself or my Ward must remain under the observation of the administering pharmacist/licensed health care provider for a period of 15 minutes (or longer if indicated by the vaccine administrator.) I understand that if I experience any adverse reactions, it will be my responsibility to follow up with my primary care physician. I understand that a paper copy and a link to an electronic copy of the COVID-19 manufacturer's Fact Sheet is available to me on request. Furthermore, I have also had an opportunity to ask questions about the COVID-19 vaccine. I understand the significant known and potential risks and benefits of the COVID-19 vaccine as explained by 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 voluntarily assume full responsibility for any reactions that may result from either my receipt of the COVID-19 vaccine or the receipt of the COVID-19 vaccine by the person named above for whom I am the Ward. If the vaccine I receive requires a second dose, 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. My medical record may be shared with my primary care provider or other healthcare provider and the medical record of my Ward may be shared with his/her primary care provider or other healthcare provider. I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives and assigns, hereby release My Nurse Now, LLC, and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt by my Ward of this or these immunization[s]. Neither My Nurse Now, LLC nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccine[s] described above. I authorize My Nurse Now, LLC to (a) notify my or my Ward's primary care provider of the vaccine administered and to provide same with copies of all vaccination records; (b) to enter my or my Ward's vaccine information on the Georgia Registry of Immunization Transactions; and (3) make any other disclosures required by law. My Nurse Now, LLC will use and disclose your personal and health information or the personal and health information of your Ward, to receive payment of the care we provide, and for other health care operations. Healthcare operations generally include those activities performed to improve the quality of care. I acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____
SIGNATURE/LEGAL GUARDIAN DATE OF VACCINATION/DATE FACT SHEET OR VIS GIVEN

_____
PRINT

Administrative Record: For Practice Use Only

ADMINISTRATIVE RECORD (For Pharmacy Use ONLY)					
VACCINE:	EXPIRATION DATE:	VACCINE:	EXPIRATION DATE:	VACCINE:	EXPIRATION DATE:
VIS VERSION/DATE:	DATE ADMINISTERED	VIS VERSION:	DATE ADMINISTERED:	VIS VERSION:	SITE OF INJECTION:
MANUFACTURER:	DOSAGE:	MANUFACTURER:	DOSAGE:	MANUFACTURER:	DOSAGE:
LOT NUMBER:	ROUTE OF ADMIN:	LOT NUMBER:	ROUTE OF ADMIN:	LOT NUMBER:	ROUTE OF ADMIN:
BRAND NAME:	DATE NEXT VACCINE DUE (IF APPLICABLE):	BRAND NAME:	DATE NEXT VACCINE DUE (IF APPLICABLE):	BRAND NAME:	DATE NEXT VACCINE DUE (IF APPLICABLE):
1ST DOSE	Entered in GRITS	**2ND DOSE**	Entered in GRITS	DATE ADMINISTERED:	DATE M.D. NOTIFIED

PAYMENT INFORMATION			
VACCINE FEES:	N/A	TOTAL CHARGE:	N/A

Administering Practice Name

Practice Name: My Nurse Now, LLC

ADDRESS: 7070 Hodgson Memorial Dr. Savannah, Ga 31406

TELEPHONE NUMBER 912-598-6322

ADVERSE EVENTS/COMPLICATIONS & NOTES

Report all adverse reactions to the Federal Vaccine Adverse Event Reporting System