COVID Vaccine Consent Form

Patient Information:

NAME (Last)	(First)	DATE OF BIRTH	GENDER
ADDRESS			EMAIL
CITY	STATE	ZIP	PHONE No
PRIMARY CARE PHYSICIAN: Name		Address	Phone Number
EMERGENCY CONTACT: Name		Relation	Phone Number

Circle your response below:

Is this the patient's first Yes/No or second Yes/No dose or third (Booster) Yes/No dose of the COVID-19 vaccination?

Booster Shot ONLY:

Date of your 2nd dose vaccine: _______________

Type of your vaccine series: Moderna or Pfizer

Potential Contraindications: Please Check mark the response.

	YES	NO
1. Are you feeling sick today?		
2. 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?		
3. Have you received any vaccines in the past 14 days?		
4. Were you tested positive for Covid-19 in past 90 days?		
5. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days?		
6. Do you have a bleeding disorder or are you taking a blood thinner?		
7. For women, are you currently pregnant or breastfeeding?		
8. Are you interested in learning more about products and services of East Norriton Pharmacy?		

Medicare Or Insurance Information: (Please bring a copy of your Insurance or Medicare (Red/Blue) Card):

Name of Insurance or Medicare Card:	BIN#:
Member ID:	GRP#:
PCN#:	

***ONLY If Uninsured**, you must check the box below to attest that the following information is true and accurate: I Name: ___________________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 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.

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*SSN# or State Id. # or Driver's License # & State

Only for Booster Shot, you must sign your name below to attest that the following information is true and accurate: I Name: ___________________ have moderately to severely immunocompromised conditions to receive an additional dose of a COVID-19 Vaccine (Pfizer or Moderna) at least 28 days after the completion of the initial mRNA COVID-19 vaccine series.

Please circle your response below:

Race:	Ethnicity:
American Indian or Alaska Native	Hispanic
Asian	Not Hispanic or Latino
Native Hawaiian/Other Pacific Islander	Unknown
Black or African American	
White	
Other Race	

DISCLOSURE OF RECORDS

I understand that EAST NORRITON 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 EAST NORRITON 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 EAST NORRITON PHARMACY will use and disclose my health information as set forth in the EAST NORRITON PHARMACY Notice of Privacy Practices (copy is available in-store, by requesting a paper copy from the pharmacy).

LIABILITY RELEASE AND WAIVER

1. I, the undersigned acknowledge that I wish to be vaccinated against COVID-19.
2. The benefits of receiving the Vaccination has been explained to me, or I have had the opportunity to research them for myself and I fully understand and appreciate the dangers, hazards, and risks that may arise from not being vaccinated. These dangers, hazards, and risks can result in impairment to my body, general health, well-being, and could include serious or even fatal results.
3. Knowing the dangers, hazards, and risks of not receiving the Vaccination, on behalf of myself, my family, spouse, heirs, and personal representative(s) (the "Releasors"), I agree to assume all the risks and responsibilities surrounding my failure to be vaccinated. On behalf of myself and the Releasors I hereby covenant not to sue East Norriton Pharmacy its trustees, officers, representatives, volunteers, and employees ("Releasees"), and I hereby release, waive, and forever discharge the Releasees from and against any and all liability for any harm, injury, damage, claims, demands, actions, causes of action, costs, and expenses of any nature that I may have or that may hereafter accrue to me or a Releasor, arising out of, or related to, my failure to receive the Vaccination. It is my expressed intent that this Liability Release and Waiver shall bind me, the members of my family and spouse, if I am alive, and my estate, family, heirs, administrators, personal representatives, or assigns, if I am deceased, and shall be deemed as a legally binding release, waiver, discharge and covenant not to sue the Releasees. I have truthfully answered all the questions regarding my medical history that are listed above.
4. I voluntarily request and consent that an employee by East Norriton Pharmacy administer to me the following vaccine(s) ("Vaccine") I have had an opportunity to ask the East Norriton Pharmacy pharmacist any questions about the Vaccine or about information in the Vaccine Information Statement and my questions have been answered to my satisfaction.
5. I understand that there is a likelihood that I will experience an adverse reaction from the administration of the Vaccine. After careful consideration, I believe that the benefits of receiving the Vaccine outweigh the risks associated with receiving the Vaccine and I have decided to have the East Norriton Pharmacy administer the Vaccine to me East Norriton Pharmacy shall not, at any time, or to any extent allowable by applicable law, be liable, responsible, or in any way be accountable for any loss, injury, death, or damage suffered or sustained by me or any other person at any time in connection with, or as a result of, the administration of the Vaccine to me by the East Norriton Pharmacy.
6. I, for myself, my heirs, executors, personal representatives and assigns, hereby release East Norriton Pharmacy, its employees and contractors, specifically the administering pharmacist, its agents or representatives from any and all claims arising out of, in connection with, or in any way related to my receipt of the Vaccine from East Norriton Pharmacy as allowed by applicable law.
7. If applicable by signing below, I certify that I am the vaccinated or the vaccinated's patent/legal guardian.
8. I hereby agree to abide by all rules, instructions, policies and procedures imposed by the Releasee relating to the use of the facilities or property.
9. I certify I am signing this of my own free will and accord, voluntarily and without duress.
10. This entire document is to be construed as if written mutually by all parties and any commencement action shall be in Montgomery County Pennsylvania.

THIS IS A LEGAL AGREEMENT AND INCLUDES A RELEASE OF LEGAL RIGHTS. READ AND BE CERTAIN YOU UNDERSTAND IT BEFORE SIGNING.

Print Name: ___________________________Signature: ___________________________________Date: __________

FOR ADMINISTRATIVE USE ONLY

Vaccine	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
Covid – 19	0.3 ml ☐ 1st 0.3 ml ☐ 2nd	☐ IM - LD ☐ IM - RD		Pfizer			

Vaccine	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
Covid – 19	0.5 ml ☐ 1st 0.5 ml ☐ 2nd	☐ IM - LD ☐ IM - RD		Moderna			