COVID-19 Spikevax (Moderna) Consent Form 2024-2025

HEALTH CARE PHARMACY, INC
1030 PRESIDENT AVENUE
FALL RIVER, MA 02720

I am eligible for a booster dose of vaccine as I am over the age of 18 and at least 2 months have passed since my last COVID vaccine

VACCINE RECIPIENT INFORMATION

Last Name | First Name | Date of Birth | Gender

Address | City | State | Zip

Primary Phone Number | Primary Care Physician (PCP) | PCP Phone

INSURANCE INFORMATION

Plan Name | RX BIN | RX PCN | Cardholder ID | RX Group

Medicare A/B ID Number

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 Health Care 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 record to act on this request. I request that payment of authorized benefits be made on my behalf. **DISCLOSURE OF RECORDS:** I understand that Health Care 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 HCP (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. I also understand that HCP will use and disclose my health information as set forth in the HCP Notice of Privacy Practices (copy available in-store or by requesting a paper copy from the pharmacy). 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 clinical coordinator.

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

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

VACCINE ADMINISTRATION INFORMATION (for Immunizer/Pharmacist use only)

	10/19/23	Moderna	0.5mL	3043152 / 8079568	05/26/25 / 5/6/25	L Arm / R Arm
Admin Date	VIS Date	Manufacturer	Volume	Lot # (circle)	Exp. Date (circle)	Site

IM

American Indian/Asian/Native Hawaiian/Black or African American/White/Other

Hispanic/Not Hispanic or Latino/Unknown

Route | Race (Circle) | Ethnicity (Circle)

Administering Immunizer Name & Title | Administering Immunizer Signature

Prevaccination Checklist for COVID-19 Vaccination

Name _____

For vaccine recipients (both children and adults):

The following questions will help us determine if there is any reason COVID-19 vaccine cannot be given today. **If you answer "yes" to any question, it does not necessarily mean the vaccine cannot be given.** It just means additional questions may be asked. If a question is not clear, please ask the healthcare provider to explain it.

	Yes	No	Don't know
1. How old is the person to be vaccinated? _____			
2. Is the person to be vaccinated sick today?	☐	☐	☐
3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product was administered? ☐ Pfizer-BioNTech ☐ Janssen *(Johnson & Johnson)* ☐ Another Product ☐ Moderna ☐ Novavax _____			
• How many doses of COVID-19 vaccine were administered? _____			
• Did you bring the vaccination record card or other documentation?	☐	☐	
4. Does the person to be vaccinated have a health condition or is undergoing treatment that makes them moderately or severely immunocompromised? *This would include, but not be limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.*	☐	☐	☐
5. Has the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
6. Has the person to be vaccinated ever had an allergic reaction to: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. Has the person to be vaccinated ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

8. Check all that apply to the person to be vaccinated:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a history of Guillain-Barré Syndrome (GBS)
- ☐ Have a history of COVID-19 disease within the past 3 months?
- ☐ Vaccinated with monkeypox vaccine in the last 4 weeks?

Form reviewed by _____ **Date** _____