Vaccine Consent Form

Section A: Please Print Clearly

Last Name	*First Name*	*M/I*	*Gender (M/F)*

Address	*City*	*State*	*ZIP*

Phone Number	*Date of Birth*	*Medicare B # (if applicable)*

Primary Care Provider	*Provider Phone #*	*Drivers License ID #*

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Black or African-American ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race

Ethnicity ☐ Hispanic/Latino ☐ NOT Hispanic/Latino

Section B: Please answer the following questions to determine if you are eligible to receive a vaccination today

1. Do you feel sick today?	☐ Yes	☐ No	☐ Don't Know
2. Have you had cough, fever (>100.4F), muscle pain, shortness of breath, chills, or sore throat in the past 10 days?	☐ Yes	☐ No	☐ Don't Know
3. Have you received passive antibody therapy for the treatment of COVID in the past 90 days?	☐ Yes	☐ No	☐ Don't Know
4. Do you have allergies to medications, food, or vaccines? (Example: eggs, gelatin, gentamicin, polymyxin, neomycin, phenol, thimerosal or latex) If yes, please list the allergies: _____	☐ Yes	☐ No	☐ Don't Know
5. Have you had a severe allergic reaction (e.g. anaphylaxis) to another vaccine or injectable medication in the past?	☐ Yes	☐ No	☐ Don't Know
6. Do you have a family history of anaphylaxis?	☐ Yes	☐ No	☐ Don't Know
7. For women: Are you pregnant or considering becoming pregnant in the next month?	☐ Yes	☐ No	☐ Don't Know
8. Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes	☐ No	☐ Don't Know
9. Do you smoke?	☐ Yes	☐ No	☐ Don't Know
10. Do you have cancer, leukemia, lymphoma, HIV/AIDS, organ transplant, or any other immune system disorder or are you regularly in contact with anyone who has a severely weakened immune system?	☐ Yes	☐ No	☐ Don't Know
11. Are you currently on steroid therapy, anticancer drugs, or radiation treatment (or otherwise immunocompromised)?	☐ Yes	☐ No	☐ Don't Know
12. Have you received a transfusion of blood or blood products or have you been given a medicine called immune (gamma) globulin in the past year?	☐ Yes	☐ No	☐ Don't Know

Section B:

I certify that I am: (i) the patient and at least 18 years of age; (ii) the parent or legal guardian of the minor patient; or (iii) the legal guardian of the patient. I attest that I am eligible to receive vaccination under current state public health guidance. Further, I hereby give my consent to the Hartig Drug immunization certified pharmacist, pharmacy technician or intern (under the direct supervision of a pharmacist), to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the above vaccine(s) and have received, read and or had explained to me the FDA status on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15-30 minutes after administration for observation by the administering provider. On behalf of myself, my heirs and personal representative, I hereby release and hold harmless Hartig Drug, its staff, and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I understand that my state mandates participation in a state immunization registry, in which case my immunization information will be supplied to the state unless I complete a state-approved opt-out process. (If applicable) Hartig Drug, will, if my state permits, provide me with an opt-out form. Unless I provide Hartig Drug with a signed opt-out form, I elect to participate fully in, and consent to Hartig Drug reporting my immunization information to the state's immunization registry. I authorize Hartig Drug to (1) release my medical or other information to my healthcare professionals, Medicare, Medicaid, or other third-party payers as necessary to facilitate care or payment, (2) submit a claim to my insurer for the above requested items and services, and (3) request payment of authorized benefits be made on my behalf to Hartig Drug with respect to the above requested items and services. I further agree to be fully financially responsible for any due amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of services or if Hartig Drug invoices me after the time of service, upon receipt of such invoice.

Patient/Legal Representative Signature:_____ Date:_____

Section C: To be filled out by pharmacy

Vaccine	Dose	Lot	Exp	Dosage	Site	EUA/VIS Publish Date

1. Immunizer Name (print):_____ Immunizer Signature:_____ Date:_____

2. Immunizer Name (print):_____ Immunizer Signature:_____ Date:_____

3. Immunizer Name (print):_____ Immunizer Signature:_____ Date:_____

Entered into Immunization Registry on: _____ Primary Care Provider Notified on: _____

BIN: PCN: ID: Group: