PELMEDS COVID-19 VACCINE CONSENT FORM

196 Bear Hill Road
Waltham, MA 02451
Phone: 781-966-2700 **Fax:** 781-890-0234 **Email:** info@pelmeds.com

Where Innovation Meets Medication

First Name: _____ **Last Name**: _____ **Birth Date**: ____/____/_____ **Age**: ____

Sex: ☐ Male ☐ Female ☐ Transgender ☐ Unknown **Ethnicity:** ☐Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ Asian ☐ Black ☐ Native American ☐ Pacific Islander ☐ White ☐ Other

Address: _____ **City**: _____ **Zip**: _____ **State**: _____

Phone: _____ **Do you have Insurance?** ☐ No ☐ Yes

The following questions will help determine if there is any reason you should not receive a COVID immunization.
Answering "Yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear; please ask a healthcare provider to explain.

Has the person to be vaccinated ever received a COVID-19 Vaccine?	☐ No ☐ Yes
If yes, Date: _____ Type/Brand of Covid Vaccine: _____	
Does the person to be vaccinated have an allergy to any medication, food, vaccine, Polyethylene glycol (PEG), polysorbate or latex?	☐ No ☐ Yes
List all allergies: _____	
Is the person to be vaccinated sick today?	☐ No ☐ Yes
Is the person to be vaccinated at least 18 years old?	☐ No ☐ Yes
If no, is the person to be vaccinated at least 12 years old?	☐ No ☐ Yes
IF no is the person to be vaccinated at least 5 years old?	☐ No ☐ Yes
Does the person to be vaccinated have a bleeding disorder or are they using a blood thinner?	☐ No ☐ Yes
Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19?	☐ No ☐ Yes
Has the person to be vaccinated have a history of myocarditis or pericarditis?	☐ No ☐ Yes
Is the person pregnant or breastfeeding?	☐ No ☐ Yes
Does the person have dermal fillers?	☐ No ☐ Yes

I have read, or have had explained to me, the Emergency Use Authorization (EUA) for COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to me, or the person named above for whom I am authorized to make this request (parent or guardian).

I have been informed that my vaccine information will be shared in the MIIS vaccine registry.

I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING

Print Parent/Guardian name, if different from client: _____

Client/Parent/Guardian Signature: _____ **Date**: _____

---For Pharmacy Use Only Below---

Administration/Clinic Location _____ **EUA Fact Sheet Provided:** ☐ No ☐ Yes

Date Vaccine Administered: ____/____/_____ **Date Booster Required:** ____/____/_____

Affix Label Here

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Vaccine Manufacturer: ☐Janssen (J&J) ☐ Moderna ☐ Pfizer(12 and up) ☐ Pfizer(5-11) **Lot Number**: _____

Site of IM Injection: ☐ Right Deltoid ☐ Left Deltoid ☐ Other: _____**Dose:** ☐0.5 mL ☐ 0.3mL ☐ 0.25mL ☐ 0.2ml

Dose Number ☐ 1(One)☐ 2 (Two) ☐ 3(immunocompromised 3rd dose) ☐ Booster

Signature of Vaccinator: _____ **Title of Vaccinator:** _____

Vaccinator's Comments: _____

INSURANCE INFORMATION

Primary Insurance: _____

Member name: _____

Medicare ID _____

Rx BIN: _____

Rx PCN: _____

Rx Group: _____

Member ID: _____

The information above is true to the best of my knowledge. If qualified, I authorized billing to my insurance company and release of information required to process my claims.

I authorized my insurance benefits to be paid directly to Pelham Community Pharmacy INC. D.B.A. PelMeds Pharmacy.

Client Signature: _____ Date: _____