# COVID-19 INFORMED CONSENT FORM

## PATIENT INFORMATION

PharRxmax PHARMACY

First Name: _____ Last Name: _____

Email: _____ Phone: _____ Date of Birth: _____

Address: _____ City/State: _____ Zip Code: _____

Gender: ☐ Male ☐ Female ☐ Other Age: _____ Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Prefer not to answer

Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Unknown ☐ Prefer not to answer

Emergency Contact: _____ Phone Number: _____

Primary Care Doctor: _____ Address: _____

Which COVID-19 phase do you fall under? ☐ Phase 1A ☐ Phase 1B ☐ Phase 1C ☐ Phase 2 ☐ Phase 3 ☐ Unsure

What dose of COVID-19 vaccine will this be? ☐ First ☐ Second If Second, Date of First Dose: _____

Which vaccine did you receive? ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson ☐ Other _____

| PLEASE RESPOND DAY OF VACCINE | YES | NO | N/A |
|---|---|---|---|
| Do you feel sick today? | | | |
| Have you ever had an allergic reaction to a component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures? * | | | |
| Have you ever had an allergic reaction to polysorbate? * | | | |
| Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.* | | | |
| Have you ever had an allergic reaction to a vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but is not known which component elicited the immediate reaction?* | | | |
| Have you received any vaccine in the last 14 days? | | | |
| Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? If so, when _____ ? | | | |
| Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? If so, when _____ ? | | | |
| Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? | | | |
| Do you have a bleeding disorder or are you taking a blood thinner? | | | |
| Do you have dermal fillers? | | | |
| **FOR WOMEN:** Are you pregnant or considering becoming pregnant in the next 60 days? | | | |

***** 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.

Please explain any "Yes" answers provided above: _____

_____

## INSURANCE INFORMATION: Fill the appropriate category.

☐ **Medicare or Medicaid:** Medicare #: _____ DCN #: _____

☐ **Private Insurance:** Insurer: _____ Subscriber ID: _____

Bin #: _____ PCN: _____ Group #: _____

☐ **No Insurance:** To have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for uninsured patients, please provide one of the following:

Social Security #: _____

State Identification #: _____ State of Issuance: _____

Driver's License #: _____ State of Issuance: _____

## PATIENT SIGNATURES

**The Public Readiness and Emergency Preparedness Act** (PREP Act) authorizes the CICP to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The CICP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use of covered countermeasures identified in a PREP Act declaration. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV–2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any such product. Information about the CICP and filing a claim is available by calling 1-855-266-2427 or visiting http://www.hrsa.gov/cicp/.

**Authorization to Request Payment:** I do hereby authorize Pharmax 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 records to act on this request. I request that payment of authorized benefits be made on my behalf.
Disclosure of Records: I understand that Pharmax Pharmacy may be required to or may voluntarily disclose my health information to my Primary Care Physician (if I have one), my insurance plan, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance).

**Acknowledgement of Notice of Privacy Practices:** I have received a Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Pharmax Pharmacy and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

**Consent:** I have been given a copy and have read, or had explained to me, the information in the most recent "Vaccine Information Statement" or "EUA" where applicable, for the vaccine indicated above. I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine requested and ask that the vaccine currently due for which I have signed below be given to me or to the person named above for whom I am authorized pursuant to Section 431.058, RSMo to make this request.
ShowMeVax Reporting: This notification is being provided pursuant to § 338.010.13, RSMo. I understand and acknowledge the administration of this vaccine will be entered into the ShowMeVax system administered by the Missouri Department of Health and Senior Services unless I indicate otherwise below:

If guarantor/guardian, indicate your relationship to the recipient: _____

Signature: _____

Print: _____ Date of Signature: _____

## FOR PHARMACY USE ONLY

☐ I have reviewed the Patient Information, Screening Questions, Age Guidelines, and medical conditions with the patient, if appropriate. I have also given the patient a COVID-19 vaccine information fact sheet and information on V-Safe Health Checker.

☐ Pharmacist has screened, when appropriate, for contradictions to vaccine.

☐ Pharmacist has asked that the patient stay for the appropriate amount of time after administration of vaccine.

Vaccine Manufacturer:

Lot Number:

Expiration Date: _____

Date Given: _____

Site of Intramuscular Administration: ☐ Left Deltoid ☐ Right Deltoid

Dose: ☐ First Dose ☐ Second
Administered By: _____

Supervising RPh: _____