COVID Vaccine Intake Consent Form — Red Rock Pharmacy

Patient Information

Last Name | First Name | Date of Birth

Gender | Phone Number | Social Security Number | Medicare Number

If you are part of a Senior Facility clinic, are you a resident ☐ or an employee/staff ☐ ?

Is this the patient's first ☐ or second ☐ dose of the COVID-19 vaccination?

THIS SECTION TO BE FILLED OUT BY STAFF ONLY

Insurance Information (For on site clinics, please ensure a copy of the patient's insurance card(s) was collected)

Prescription Insurance: Yes ☐ No ☐

Are you the Primary Cardholder? | If No, include the Primary Cardholders DOB

Prescription Benefit Plan Name | Cardholder ID# | RX Group ID | BIN | PCN

Medicare Fields: Yes ☐ No ☐

Is the Patient age 65 or older or Medicare Eligible? | Medicare Part A/B ID Number (MBI)
Note: MBI is required for all patients age 65 and older, or Medicare eligible. Refer to your Medicare Red, White and Blue Care.

Medical Insurance: Yes ☐ No ☐

Medical Insurance Carrier | Cardholder ID# | GroupID | Payer ID | Are you the Primary Cardholder? | If NO, include the Primary Cardholders DOB

If uninsured, you must check the box below to attest that the following informations true and accurate:

☐ I 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's COVID-19 Program 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.**

Social Security Number | or State Identification Number & State | or Driver's License Number & State

COVID-19 Screening Questions

	YES	NO	DON'T KNOW
1. In the past two weeks have you tested positive for COVID-19 or are currently being monitored for COVID-19?	☐	☐	☐
2. In the past two weeks, have you had contact with anyone who tested positive for COVID-19	☐	☐	☐
3. Have you had the new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?	☐	☐	☐

To be filled out by the immunizer: Patient Temperature: _____ Date: _____

If patient answers yes to any of these questions or patient's bodily temperature is 100 F or greater, please inform them that they should not receive the vaccine at this time, instruct them to contact their primary care provider for next steps and the facility coordinator will be notified.

Immunization Screening Questions

	YES	NO	DON'T KNOW
1. Are you sick today? (For example: a cold, fever or acute illness)	☐	☐	☐
2. Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.)	☐	☐	☐
3.Have you ever had a serious reaction after receiving a vaccination? Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	☐	☐	☐
4. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	☐	☐	☐
5. Do you take anticoagulation medication? For example: warfarin, Coumadin or other blood thinner.	☐	☐	☐
6. Do you have a long-term health problem such as heart disease, liver disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorder?	☐	☐	☐
7. Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, anklosing spondylitis, Crohn's disease or any other immune system problem?	☐	☐	☐
8. Do you have a weakened immune system or in past 3 months, taken medications that weaken it such as cortisone, prednisone, other steroids, anticancer drugs radiation treatments?	☐	☐	☐
9. During the past year, have you received a transfusion of blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10. For women are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
11. Have you received any vaccinations or TB skin test in the past 4 weeks?	☐	☐	☐

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 a 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 to whom I am authorized to make this request.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize Red Rock Pharmacy to release information and request payment. I certify that the information given by me is applying for payment under Medicare or Medicaid, of 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 Red Rock Pharmacy may require to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at Red Rock 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 purpose of treatment, payment or other health care operations (such as administration or quality assurance)). I also understand that Red Rock Pharmacy will use and disclose my health information as set forth in the Red Rock Pharmacy Notice of Privacy Practices (copy is available 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 providing to the clinic coordinator.

X _____

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

If signing on behalf of the patient, you are stating that you are authorized to provide the required consents on behalf of the patient.

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

Vaccine Administration Information for Immunizer/Pharmacist use only

Administration Date **Vaccine** **VIS Date** **Manufacturer**

Lot# **Exp. Date** **Route** **Site** **Volume**

Administering Immunizer Name & Title **Administering Immunizer Signature**