COVID-19 VACCINE IMMUNIZATION CONSENT FORM

For Covid-19 Provider Use only Clinic; Cornerstone Pharmacy Rodney Parham
Date of Service :_____

Person Receiving Vaccine

Name:_____ Date of Birth: ____/____/_____ Phone:_____
Gender: M / F Address: _____
City: _____ State:_____ Zip_____

	*YES	NO
Is this your first dose of the COVID-19 Vaccine?		
Is this your second dose of the COVID-19 Vaccine? (If yes, please disregard remaining questions. Sign and date)		
Have you had any vaccines within the previous 14 days?		
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are you currently in isolation? Are you currently in quarantine for known exposure to Covid-19?		
Have you ever had a severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component of injectable therapy such as difficulty breathing, swelling of your face and throat , fast heart beat, bad rash all over you body, dizziness and weakness?		
Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive COVID-19 vaccine. A Discussion with your health care provider can help make an informed decision.		
Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe obesity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive COVID-19 vaccine unless otherwise contraindicated.		
Have you received monoclonal antibodies of convalescent plasma as part of COVID-19 treatment? Vaccination should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced immune response.		
****NOTE:** Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21-28 days after the initial vaccine. Refer to your COVID-19 vaccination record card for the second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date.		

2. Release and Assignment
Please Read the Providers Privacy Notice. It is available at the clinic site or accompanies this form then sign below.

Insurance : AR KIDS #_____ Medicare# _____
Insurance : Card holder Name : _____ Company: _____ Rx BIN: _____
RX ID: _____ PCN :_____ Rx Group: _____ SSN:_____

My signature below indicates I have read, understood and agreed to section **2. Release and Assignment** of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA)
Signature of Patient/Parent/Guardian: _____
Date:_____

Shot site : RD / LD IM Lot # _____ Exp: _____
Given By :_____ Date: _____