2021-2022 Informed Consent to Receive COVID-19 Vaccines

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

Street Address: _____

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

Phone: (_____)_____**Mobile/Land line** (circle one)

Drug Allergies:_____

Gender Assigned at Birth: Male / Female / Unknown

Race: Asian / African-American / Hispanic / American Indian / Caucasian / Pacific Islander / Two or More / Other

Ethnicity: Hispanic or Latino / Non-Hispanic or Latino / Decline to State (unknown)

MEDICARE/INSURANCE INFORMATION

The United States federal government has declared COVID-19 a public health crisis and has issued Emergency Use Authorizations for vaccinations. As such, any vaccine is property of the United States government and will be provided at no cost to you. Administration charges may be billed to your medical or prescription insurance, or to the United States government, through a national clearinghouse. Please provide the date of birth and street address that Medicare or your insurance has on file for you.

	Prescription	Medical
Insurance Name (Medicare B, HealthPartners, etc.):		
ID # (include any letters):		
Group #:		
Payer ID #	---	
Rx BIN:		---
Rx PCN:		---

If uninsured, please provide Driver's License or State ID # _____ State: _____

_____ _____

Patient Signature **Date**

Please initial that you received our HIPAA Notice of Privacy Practices

_____ (initials)

VACCINE INFORMATION (Office use only)

Standing order provider: Dr. Robert Wolfe **Address:** 82 Chimney Rock Rd Hovland, MN 55606 **NPI:** 1205905452 **Phone:** 715-699-4976

Do NOT administer COVID-19 Vaccine with any other vaccine

Janssen ☐ (Do not need to check Dose 1 or Dose 2 box)

Dose 1 ☐

Dose 2 ☐ (1st dose product received_____ date received_____)

Vaccine	
Manufacturer	
Lot #	
Exp. Date	
EUA revision date	
Inject IM	Right or Left Arm
Dose (mL)	
Admin. / EUA given date	
Patient Age	
Store #	
Administrator*	

Attach
Rx Barcode

Attach
Rx Backtag

*By signing as administrator, you are confirming that contraindications and side effects have been reviewed and a current EUA was provided to the patient receiving vaccine.

Please complete these screening questions on the day of your immunization. The pharmacist will review your responses and determine your eligibility for receiving an immunization.

1) Have you had a positive COVID-19 test or direct, close contact with someone who has a positive test for COVID-19 in the past 10 days? **YES / NO**
2) Have you had any of the following symptoms in the previous 10 days? Fever of 100.4°F or higher when not using any fever-reducing medication, cough, new loss of taste or smell, difficulty breathing or shortness of breath, sore throat, diarrhea, or other respiratory illnesses? **YES / NO**

Please answer yes or no to the questions below. If any questions are unclear, please ask for help.	**Yes**	**No**	**Don't Know**
1) Are you feeling sick today?			
2) Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen ☐ Another product			
3) Have you ever had an allergic reaction to: (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.)			
• 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			
• Polysorbate			
• A previous dose of COVID-19 vaccine			
4) Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (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.)			
5) Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.			
6) Have you received any vaccines in the last 14 days?			
7) Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8) Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9) Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10) Do you have a bleeding disorder or are you taking a blood thinner?			
11) Are you pregnant or breastfeeding?			

NOTE: The pharmacist will review these questions with you before giving the immunization. Based on your answers, we may refer you to speak with your physician to make sure the vaccine is right for you. If you have ever experienced syncope (fainting) after immunization administration in the past, please notify the pharmacist prior to administration.

I have read, or have had read to me, the provided Emergency Use Authorization(s) ("EUA"). I have had the opportunity to ask questions about the vaccine(s), and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine. I consent to the administration of the vaccine requested. I authorize this information to be forwarded to my primary care physician, the authorizing physician, or the local Dept. of Health, if applicable. **I agree to stay in the general area for 15 to 30 minutes after receiving my vaccination in case any immediate reactions occur.** I understand that if I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); SUPERVALU INC.; the subsidiaries and affiliates of SUPERVALU INC.; the respective directors, officers, employees, and agents of SUPERVALU INC. and its subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability that might arise from this vaccination.

By providing my home, work and/or cellular telephone number, I authorize Supervalu, Inc. and its agents to contact me at the number(s) provided, including by calling or texting me using an autodialer or pre-recorded messages, to communicate with me about any of the pharmacy products or services that I have received from Supervalu, Inc. This includes, but is not limited to, contacting me about refill reminders and when future vaccines are due for administration. I understand that message and data rates may apply and that I will have the option of stopping or opting-out of receiving future messages. I understand that I am not required to allow Supervalu, Inc. and its agents to contact me at the number(s) provided above in order to purchase products or services from Supervalu, Inc.