COVID Vaccine Intake Consent Form

☐ Moderna: ☐ 1st Dose ☐ 2nd Dose

PATIENT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Date of Birth: _____ Gender: _____

PRIMARY CARE PROVIDER (PCP)

PCP Name: _____ PCP Phone: _____

INSURANCE INFORMATION

The vaccines are free to everyone, regardless of whether you have private or government insurance or no insurance at all.

☐ A copy of my insurance card has been provided. ☐ Please call me to verify my insurance information.

☐ Realo Drugs has my health insurance information on file from filling prescriptions.

☐ 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 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

1.	Have you experienced any of the following symptoms in the past 48 hours: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea?	**YES NO**
2.	Within the past 14 days, have you been in close physical contact with anyone who is known to have laboratory-confirmed COVID-19 OR anyone who has any symptoms consistent with COVID-19?	**YES NO**
3.	Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	**YES NO**
4.	Are you currently waiting on the test results of a COVID-19 test?	**YES NO**

DISCLOSURE STATEMENT

Life threatening allergic reactions to vaccines are very rare. Signs of a serious allergic reaction include: shortness of breath, hoarseness of wheezing, hives, paleness, weakness, elevated heart rate, or severe dizziness. These symptoms may occur within a few minutes, or up to 48 hours after the vaccination. If you are experiencing any of these symptoms, you should contact a healthcare provider immediately.

CONSENT

I certify that I am: (a) at least 18 years of age (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an "applicable Provider"), to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine. I understand that the health data shared with Realo Drugs will be used to determine my eligibility for receiving the COVID-19 vaccination and further determine timing of when the vaccine will be made available to me.

I have read and agree to the terms above. **I agree to wait near the vaccination location for approximately 15-30 minutes for observation by the pharmacist.**

Signature: _____ Date: _____

FOR OFFICE USE ONLY

Vaccine Lot & Exp Date: _____ | _____ Administration Time: _____ AM | PM

Route: LD RD Wait Time: 15 min 30 min Administered by: _____