Informed Consent for Immunization with COVID-19 Vaccine

							M DF	Other
Last Na	ame	First Name	Middle	Date of Birth	Age		Gende	er
					()	-		
Home	Address	City	State	Zip	Phone # Home	□Cell		
Medica	Medicare Part B ID# or last 4 digits of SSN: Driver's License #:							
	□Asian □ Black or African Am ty: □Hispanic or Latino □Non-			acific Islander DTwo	o or More DOther	:		
	arm do you prefer for vaccine? e circle) Left Right	Enter weight IF LESS than	66 pounds:Lbs.		vider Name: vider Address:			
Screen	ing Questionnaire: Please answe	questions by checking the L	boxes.					
Screen	ing Questions – NOTE: IF COMPL	ETED ONLINE, REVIEW ANS	WERS WITH PATIENT TO EN	SURE NO CHANGES		Yes	1	No
1.	Are you sick today?							
2.	Have you ever received a dose of If yes, which product did you re		Moderna 🗖 Other:	Date:				
3.	Have you ever had an allergic re polyethylene glycol (PEG) or pol		19 vaccine or any component	of the COVID-19 vacc	ine, including			
4.	Have you ever had an allergic reaction to another vaccine (other than COVID-19) or to an injectable medication?							
5.	Have you ever had a severe alle latex? If yes, please list:	rgic reaction (anaphylaxis) t	o any food, pet, environment	al allergens, oral mec	lications, or			
6.	Have you received any vaccines	in the past 14 days? (not a	contraindication)					
7.	Have you received passive antik	oody therapy (monoclonal a	ntibodies or convalescent seru	um) as a treatment fo	or COVID-19	П		

Informed Consent: Please read and sign.

within the last 90 days?

Are you pregnant or breastfeeding? (not a contraindication)

By my signature below, I consent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist or technician, or other authorized person, where permitted by law or state/federal guidance, employed or contracted by Albertsons Companies or one of its affiliated pharmacies and to be contacted at the number provided above regarding other immunizations for which I am due or eligible to receive. I also release Albertsons Companies and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting, or arising from my receipt of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination and understand that I am obligated to pay for all products and services received, if applicable. 2) I may be responsible for payment after the date of service if the product or service is billed to my medical benefit. 3) I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient. 4) I will immediately alert the pharmacist of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine. 5) I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects. 6) I should remain in the area for observation for 15 minutes unless I have a history of an immediate allergic reaction of any severity to a vaccine or injectable therapy or if I have a history of anaphylaxis due to any cause I should remain in the area for observation for 30 minutes after the vaccination. If I leave the area without waiting, I acknowledge that I am doing so at my own risk and against the advice of the professional who administered the vaccine. 7) I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization ("EUA") provided for the vaccine(s) to be administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). 8) I have been offered and/or provided a copy of the company's Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA). 9) This vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting by my pharmacy or its business associate to an immunization registry, which may share my immunization data with others, and to my primary care physician, the authorizing physician, or the local Department of Health, if applicable, and I authorize these disclosures. (New Jersey Only: I authorize _____ do not authorize _____ reporting of my receipt of this vaccination to my primary care provider I understand that failure to check authorize/do not authorize will serve as authorization.) (South Dakota and Massachusetts only: I understand I have the right to object to the sharing of my data to the abovementioned parties through such registries.)

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Signature of Patient or	Date								
For Pharmacy Use Only									
Vaccine Name	Lot #	Expiration Date	Manufacturer	Dose (ml)	Dose #	Route	Site (circle)	VIS/EUA Publication	
								Date	
							R / L Deltoid		
Name of Administrator	Administr	ation Date:	C	NPP Offer	ed RPh Counse	ling (Please circle):	Accepted / Declined		
RPh Signature [Indicates (1) VIS/EUA Provided (2) Counseling Offered and (3) Patient Eligibility Verified]:									
WA ONLY: Substitution Permitted:				Dispense	as Written:				
RxBIN: PCN:		_PCN:	Group#:		ID#:				
Medical (Name, ID#, Group#, Payer ID - if UHC):									
Billing Info (off-site only		Clinic Addres	ss:						