Informed Consent – COVID-19 Vaccination Booster

SECTION A ***Information About Individual to Receive the COVID-19 Vaccination Additional Dose/Booster (please print clearly)***

Vaccine Recipient Information ☐ Resident ☐ Facility Staff ☐ Other

First name: _____ M.I.: _____ Last Name: _____

Date of birth: _____ Age: _____ Gender: ☐ Female ☐ Male Phone: _____

Home address: _____ City: _____ State: _____ Zip Code: _____

Facility Name:_____ County: _____

Power of Attorney (POA)/Legal Guardian Information *(if applicable)*

First name: _____ M.I.: _____ Last Name**:** _____

Primary Care Provider Information

☐ My Primary Care Provider is the facility's medical director. Medical Director's Name: _____

☐ I have an established relationship with a Primary Care Provider. Primary Care Provider's Name: _____

☐ I do not have a Primary Care Provider.

Billing Information *Provide copies of insurance cards (if applicable)* ☐ NO Insurance *(*If no insurance, please still provide SSN or DL information)*

☐ Medicare: Medicare Number: _____ *Social Security or Driver's License Number: _____

☐ Rx Insurance: Plan Name: _____ Rx ID Number: _____

Rx Group: _____ Rx BIN: _____ Rx PCN: _____

SECTION B ***Screening for Vaccine Eligibility***

1. Have you received previous COVID-19 vaccinations? If yes, complete the information below. **Primary Series** Vaccine Brand (i.e. Pfizer, Moderna, etc.): _____ Dose #1 Date *(Month/Day/Year)*: _____ Dose #2 Date *(Month/Day/Year)*: _____ *If applicable, Immunocompromised ONLY* Dose #3 Date *(Month/Day/Year)*: _____ **Booster(s)** – List Vaccine Brand and Date Administered *(Month/Day/Year)* Booster #1: _____ Booster #2: _____ Booster #3: _____	☐ Yes ☐ No ☐ Don't know
2. In the past two weeks, have you received any other vaccine(s)?	☐ Yes ☐ No ☐ Don't know
3. Have you received monoclonal antibody treatment in the past 90 days?	☐ Yes ☐ No ☐ Don't know
4. Do you feel sick today?	☐ Yes ☐ No ☐ Don't know
5. Do you have allergies to latex, oral or injectable medications, food, or vaccines? (If yes, list your allergies): _____	☐ Yes ☐ No ☐ Don't know
6. Have you ever had a severe allergic reaction (i.e. anaphylaxis) after receiving a vaccination or injectable therapy?	☐ Yes ☐ No ☐ Don't know
7. For women: Are you pregnant, possibly pregnant, or considering becoming pregnant in the next month?	☐ Yes ☐ No ☐ Don't know

SECTION C ***Consent***

I certify that I am: (a) the patient and 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 Absolute Pharmacy and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the COVID-19 vaccine. I understand that it is not possible to predict all possible side effects or complications associated with receiving the COVID-19 vaccine. I understand the risks and benefits associated with the COVID-19 vaccine and have received, read and/or had explained to me the Vaccine Information Statement and/or the Emergency Use Authorization fact sheet. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for observation for the time specified by the applicable Provider after administration. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the COVID-19 vaccine.

I GIVE CONSENT to the applicable Provider for the individual named in Section A to be vaccinated with the COVID-19 vaccine.

Individual Signature, Signature of POA, or Printed Name of POA/verbally acknowledged by licensed facility staff (*sign/print name and credentials):*

X _____ **Date:** _____

Vaccine Administration Record – COVID-19 Vaccination Booster

Vaccine Recipient Information ☐ Resident ☐ Facility Staff ☐ Other

First name: _____ M.I.: _____ Last Name: _____

HEALTHCARE PROVIDER USE ONLY BELOW THIS LINE

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Clinic/Pharmacy Name: Absolute Pharmacy
Address: 7167 Keck Park Circle, North Canton, OH 44720
NPI: 1396719076

SECTION D ***Mark the Booster to be Administered***

- ☐ **Booster – 1**
- ☐ **Booster – 2**
- ☐ **Booster – 3**

SECTION E ***Complete DURING Vaccine Administration – BOOSTER***

1. I have reviewed the **Vaccine Recipient Information** and **Screening Questions** with the patient. Initial here: _____
2. I have verified whether the person is a **resident or staff member** of the facility. Initial here: _____
3. I have confirmed this individual is **eligible to receive** a booster. Initial here: _____
4. I have verified the **Vaccine NDC** matches the NDC on the bottom of this VAR. Initial here: _____
5. I have provided the patient with the **Emergency Use Authorization Fact Sheet** or **Vaccine Information Statement** and **counseling**, as applicable. Initial here: _____
6. I have provided the patient with a completed **COVID-19 Vaccination Record Card**. Initial here: _____

Vaccine Information & Dose/Route Given: ☐ Pfizer COVID-19 Bivalent Booster NDC: 59267-0304-01 0.3 mL/IM ☐ Moderna COVID-19 Bivalent Booster NDC: 80777-0282-05 0.5 mL/IM ☐ Other _____	**Lot:** **Expiration:** **Injection Site:** L Arm R Arm **Needle Gauge/Length:** 25G 1in 25G 5/8 in Other: _____
Vaccine Administrator Printed Name/Title:	**Vaccine Administrator Signature:**
Notes:	**Date Administered:**

After vaccine administration, fax the completed Vaccine Administration Record (VAR) to Absolute Pharmacy (1-800-858-7394).