

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

First name: _____ M.I.: _____
 Date of birth: _____ Age: _____
 Home address: _____
 Facility Name: _____

☐ Resident ☐ Facility Staff ☐ Other
 Last Name: _____
 Gender: ☐ Female ☐ Male Phone: _____
 City: _____ State: _____ Zip Code: _____
 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.
☐ I have an established relationship with a Primary Care Provider.
☐ I do not have a Primary Care Provider.

Medical Director's Name: _____
 Primary Care Provider's Name: _____

Billing Information Provide copies of insurance cards (if applicable)

☐ Medicare: Medicare Number: _____
☐ Rx Insurance: Plan Name: _____
 Rx Group: _____ Rx BIN: _____

☐ NO Insurance (*If no insurance, please still provide SSN or DL information)
 *Social Security or Driver's License Number: _____
 Rx ID Number: _____
 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: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
2. In the past two weeks, have you received any other vaccine(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
3. Have you received monoclonal antibody treatment in the past 90 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
4. Do you feel sick today?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
5. Do you have allergies to latex, oral or injectable medications, food, or vaccines? (If yes, list your allergies): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
6. Have you ever had a severe allergic reaction (i.e. anaphylaxis) after receiving a vaccination or injectable therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
7. For women: Are you pregnant, possibly pregnant, or considering becoming pregnant in the next month?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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.

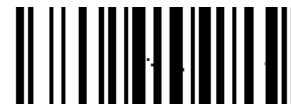
Individual Signature, Signature of POA, or Printed Name of POA/verbally acknowledged by licensed facility staff (sign/print name and credentials):

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

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: <input type="checkbox"/> Pfizer COVID-19 Bivalent Booster NDC: 59267-0304-01 0.3 mL/IM <input type="checkbox"/> Moderna COVID-19 Bivalent Booster NDC: 80777-0282-05 0.5 mL/IM <input type="checkbox"/> 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).