Good Value Pharmacy

# COVID-19 VACCINATION Screening and Consent Form

Patient's Name _____ Date of Birth _____ Date _____

Address_____ Zip_____City_____Phone Number_____

☐ Male ☐ Female Last 4 SSN_____ Month/Year of last COVID vaccine: ___/___ ☐ Pfizer ☐ Moderna

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1. Are you currently under isolation or quarantine due to COVID-19? Yes ☐ No ☐
2. Are you sick today? (fever, cough, shortness of breath, nausea/vomiting in the last 24 hours) Yes ☐ No ☐
3. Have you previously received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T cell therapies? Yes ☐ No ☐
4. Have you ever had a severe allergic reaction to any vaccine or injectable medication? If yes, list medicine/reaction: _____ Yes ☐ No ☐
5. Do you have a history of myocarditis, pericarditis, or Multisystem Inflammatory Syndrome (MIS-C or MIS-A)? Yes ☐ No ☐
6. Are you diagnosed or treated for a moderate to severe immune compromise that may include cancer treatments, organ transplant, HIV, moderate to severe primary immunodeficiency, high dose steroids (or other immunosuppressive drugs), and chronic medical conditions with immune deficiency? _____ Yes ☐ No ☐

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**Good Value Pharmacy participates in the Wisconsin Immunization Registry (WIR) Program. Participation in WIR is required for administration of the COVID-19 vaccine. I agree to allow my COVID-19 vaccination record to be entered into the WIR. I have been given a copy of the FDA Emergency Use Authorization Fact Sheet for the COVID-19 vaccine. I have read the FDA Emergency Use Authorization Fact Sheet and have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of this vaccine and ask that the vaccine be given to me or the person for whom I am authorized to make this request. I have been made aware of the appropriate time I am expected to be monitored for post-vaccination reactions based on my risk factors. I hereby attest to the best of my knowledge that I am currently eligible to receive the COVID-19 vaccine as determined by the Wisconsin Department of Health Services and Wisconsin State Disaster Medical Advisory Committee (SDMAC).**

Signature _____ Date _____ Relationship to Recipient (if applicable) _____

*****please provide your insurance card(s) to pharmacy staff*****

## FOR OFFICE USE ONLY

Lot #: _____ Expiration Date: 3/24 4/24 5/24 6/24 7/24 8/24 Manufacturer: _____

Site of Injection: ☐ Right Deltoid ☐ Left Deltoid Route: IM ☐ Entered into WIR ☐ Paid claim

Signature of Vaccine Administrator: _____ Date: _____

Vaccine Administrator: AB AW BB DF EE GC KF LL MS RS SC Other:_____

DUR PH MA 3N 15 Clarification Code: 10

Medicare: BIN 004766 PCN USFLU Medicaid: BIN 004766 PCN WIDME VA: BIN 004336 PCN ADV Group RX3841 ID 10 digit Veteran ID or SSN