COVID Vaccine Intake Consent Form

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version 3	l Form 1 of 2 to be completed
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Clinic ID	Clinic Name	Telephone	St	ore l	Number	
Address		City State	Zi	p		
Patient Infor	mation					
Last Name		First Name Date of Birth	G	ende	 er	
Address		City State	Zi	р		
Primary Care Pro	vider (PCP) Name	PCP Phone Number PCP Fax Number	P Fax Number			
PCP Address		City State	Z	Zip		
Are you a resi	ident O of a Long Ter	m Care facility or an <mark>employee/staff member</mark> ○ ?				
Is this the pat	ient's <mark>first</mark> O or secor	nd O dose of the COVID-19 vaccination?				
Insurance In	formation: (For onsite	e clinics, please ensure a copy of the patient's insurance card(s)	was	colle	ected)	
* INDICATES R	EQUIRED FIELDS					
Prescription I	113ui ai ice	es O No you the primary cardholder? *If no, include the primary	cardi	holde	or's DOR	
	AIC.	you the primary cardinolder:	carui	iolae	31 3 000	
*Prescription Ber	nefit Plan Name *Ca	ardholder ID # *RX Group ID *BIN *PCI	N			
Medicare Fiel	lds:					
○ Yes ○ No						
*Is the Patient ag or Medicare Eligil		*Medicare Part A/B ID Number (MBI) Note: MBI is required for all part older, or Medicare eligible. Refer to your Medicare Red, White, and Blue		_	65 and	
Medical Insu	rance:		<u>+D</u>			
○ Yes ○ No	*Medical Insuranc	e Provider *Cardholder ID # *Group ID	*Paye	er ID		
	e primary cardholder?	*If no, include primary cardholder's DOB				
*If uninsured,	, you must check the	box below to attest that the following information is true and	d acc	cura	ate:	
_	e any insurance, includir	ng but not limited to Medicare, Medicaid or any other private or govern				
		tration fee paid for by the United States Health Resources & Services A				
		ients, please provide either (a) a valid Social Security number, (b) state a driver's license number and the state of issuance.	ident	tifica	ation	
riambor and	otato or 100aa 1100, 011 (0)	a arror o nocinco marmos arra arro otato or nocaarros.				
*Social Security N	Number or S	State Identification Number & State or Driver's License Number & S	tate			
Detential Co.	ntusindisations		\/ T 0		DON'T	
	ntraindications			NO	KNOW	
	eling sick today?		0	0	0	
•	ver received a dose of \circ th vaccine product? \circ	COVID-19 vaccine? Pfizer O Moderna O Another product:	— —	0	0	
		ic reaction (e.g., anaphylaxis) in the past? Example: a reaction for ephrine or EpiPen®, or for which you had to go to the hospital?	\circ	0	0	
Was the se	vere allergic reaction a	fter receiving a COVID-19 vaccine?		\bigcirc	0	
Was the se	vere allergic reaction a	fter receiving another vaccine or injectable medication?				
Was the se Polyethyler	•	elated to receiving Polyethylene Glycol or products containing		\bigcirc	\bigcirc	
		elated to receiving Polysorbate or products containing Polysorbate?				

Potential Contraindications continued 4. Have you received any vaccines in the past 14 days? 5. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days? Potential Considerations 6. Do you have a bleeding disorder or are you taking a blood thinner? 7. For women, are you currently pregnant or breastfeeding? CONSENT FOR SERVICES: I have been provided with the Vaccine Information Share read the Information provided about the vaccine (s) that I am receiving. I have read the Information provided about on was a significant or any assistance of a significant or any reactions that were answered to my satisfaction. I understand the chance to ask questions that were answered to my satisfaction. I understand the chance to ask questions that were answered to be monitored for any potential adverse reactions. I understand if I experience side effects that I should of the following: call pharmacy, contact doctor, call 911. Treguest that the vaccine be given to me or to the person and above for whom I am authorized to make this request. State of Georgia ontir. I verify a pharmacist asked for my health instorpation (Stuch as administration or pully assurance). I also privately and whether I have had a physical exam within the past year. Health care providers and the classification of the position of the po							Version 3 Form 2 of 2	to be	com	nleted
Potential Contraindications continued 4. Have your received any vaccines in the past 14 days? 5. Have your received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days? Potential Considerations 6. Do you have a bleeding disorder or are you taking a blood thinner? 7. For women, are you currently pregnant or breastfeeding? COMENT FOR SERVICES, there been provided with the Vaccine Information of COVID-19 theyean for Universidate Planting of Covideration of C	Las	t Name	First N	ame		Date of Birth	rension o	10 50	COII	ipicico
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