One Source Homecare Pharmacy
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COVID-19 VACCINE INFORMATION AND CONSENT FORM

Name: _____ _____ _____
First Middle Last

Address: _____ _____ _____ _____
Street City State Zip

Telephone: (_____) _____--_____ _____
SSN

Date of Birth: _____--_____--_____	Age:	**Gender:** ☐Male ☐ Female	**Primary Language:** ☐ English ☐Other _____	**Ethnicity: (check only 1)** ☐ Not Hispanic ☐ Hispanic ☐ Unknown

Race: (check only 1) ☐Asian/Polynesian ☐Black ☐Multiracial ☐White ☐Native Am/Alaskan ☐Unknown

Please answer the health questions below:	**Yes**	**No**	**Do Not Know**
1. Are you sick today or currently in an isolation period for COVID-19?			
2. Have you had a positive COVID-19 test in the last 90 days and received convalescent plasma?			
3. Are you allergic to anything including any food, any vaccine, any vaccine component, latex, or polyethylene glycol?			
4. Do you have an adrenaline auto injector (EpiPen) for severe allergic reactions?			
5. Have you ever had a serious reaction after receiving a vaccination or IV injectable medications?			
6. Have you received any vaccinations in the past two weeks?			
7. Are you currently receiving anticoagulation therapy, or do you have any type of bleeding disorder?			
8. Do you, anyone you live with or take care of, have a weakened immune system?			
9. Do you, anyone you live with or take care of, take steroids, anti-cancer drugs or x-ray treatments?			
10. Is it possible that you are or may become pregnant in the next four weeks?			
11. Are you currently breastfeeding?			

I have been given a copy and have read the Emergency Use Authorization (EUA) or the Vaccine Information Statement (VIS) for the COVID-19 Vaccine. I have had the chance to ask questions that were answered to my satisfaction. I believe that I understand the benefits and risks of the vaccine requested and ask that the vaccine indicated be given to me or the person named for whom I am authorized to make this request.

My signature acknowledges that I was advised to remain on site for 15 minutes after receiving the vaccine.
Those with previous anaphylactic reactions should stay for 30 minutes.

_____ _____ X_____
Date **Print Name** **Patient/Guardian Signature**

OFFICE USE ONLY **Record of Immunization** **OFFICE USE ONLY**

Manufacturer	**Lot #**	**Expiration**	**Dosage**	**Route**	**Site**	**EUA/VIS**	**Provider Signature/Date**

D4 12/2020