VACCINATION ADMINISTRATION AND CONSENT FORM

Your Vaccination Clinic is scheduled for ________________ at ____________.

- Please complete ALL FIELDS in 'Sections 1, 2 & 3' below. (Please print clearly.)
- Bring your Vaccine Card(s) and this completed 2-page Consent to clinic.
- Fax this Completed page to **970.461.9089** by ________________

Community: ____

☐ Asst'd Living/MemoryCare ☐ Indep Living ☐ Skilled/Rehab ☐ Staff

Vaccine(s) requested: ☐ Moderna ☐ Pfizer ☐ HD Flu (over age 65) ☐ Standard Flu (under age 65)

Section 1.

Information about Patient:

Last Name: ______________________________ First Name: ________________________

DOB: _______ / ________ / _______ Age: _______ Gender: ☐ Male ☐ Female

Address:____ Apt/Room#: ____________

City/State/Zip: _________________________________ / ___CO __ / ____________________

Phone:(_______)____________________ Email:______________________________________

Section 2.

Race (check all that apply): ☐ American Indian / Alaska Native ☐ Asian ☐ Black / African American

☐ Native Hawaiian / Pacific Islander ☐ White ☐ Other ☐ Decline to Provide

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Section 3.

Insurance:

Medicare Part B Number: ____ (on red, white & blue card)

Social Security #: ____________________________________ (for insurance confirmation purposes only)

Medicaid Number (if applicable) _________________________

Primary Insurance Carrier: Phone Number: (_______)________________ Rx Bin: ______________

Rx PCN: ______________ Grp #: ______________ ID#: ____________________________

Community: ______________________________

Patient Name: ______________________________

D.O.B:_______________

Vaccine requested: ☐ Moderna ☐ Pfizer ☐ HD Flu ☐ Standard Flu

Before getting a vaccination please answer the following questions:	Yes	No	Don't know
1. Are you sick today, have a fever, or had COVID-19 in the last 90 days? **If yes, when:**			
2. Are you allergic to any medications or foods? (Examples: Eggs, Bovine Protein, Gelatin, Latex, Gentamicin, Polymyxin, Phenol, polysorbate, polyethylene glycol, or Thimerosal) **If yes, please list the allergies:**			
3. Have you had a severe allergic reaction (needed epinephrine or hospital care) to a previous dose to this vaccine or to any of the ingredients of this vaccine?			
4. Do you have a chronic condition, long-term health problem or are you immunocompromised? **If yes, please list:**			
5. Have you ever had a neurological disorder, or have you been diagnosed with Guillain-Barre' Syndrome?			
6. Have you received any dermal fillers (Juvaderm, Restylane etc..)? (only applies to mRNA vaccines)			
7. Do you have a history of heparin-induced thrombocytopenia (HIT)?			
8. Do you have a bleeding disorder, are on long term aspirin therapy, or take other blood thinners?			
9. Do you have a history of myocarditis or pericarditis? (especially males ages 12-29 yrs after receiving a dose of mRNA vaccine)			
10. Have you had convalescent plasma or monoclonal antibodies as part of COVID-19 treatment in the past 3 months?			
11. Do you have a history of Multisystem Inflammatory Syndrome known as MIS-A after a COVID-19 infection?			

I have read or had explained to me the Fact Sheet for Recipients and Caregivers for the use of the COVID-19 vaccine and understand the benefits and risks to me or my child of receiving this vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I hereby release Good Day Pharmacy, its employees, representatives and agents from any liability for any results which may occur from the administration of this vaccine. * I understand that by signing below I am responsible for payment if insurance is not provided or my insurance company denies payment to Good Day Pharmacy.

Patient (or POA) Signature:______________________________ **Date**:_______________

****For Good Day Pharmacy use only****

Name of VIS Provided: Influenza 8/6/21 ___ / PPSV23 10/30/19 ___ / PCV13 2/4/22 ___ / Zoster Recomb 2/4/22 ___

Immunizer Name (circle one):______________________/_ Other: ______________________________

Immunizer Signature:______________________________ Date of Admin:_______________

Vaccine	Lot#	Exp Date	Manufacturer	Dosage	Site of Injection
Pfizer (Comirnaty / Moderna (Spikevax)				0.3ml / 0.5ml	L / R Deltoid IM
Flu: High Dose / Standard (Quad)				0.7ml / 0.5ml	L / R Deltoid IM
Pneumococcal: PV20			Merck / Pfizer	0.5ml	L / R Deltoid IM
Shingrix			GSK	0.5ml	L / R Deltoid IM

Community/agency to provide copy of consent form to patient's primary care physician