Clear Form

# COVID Vaccine Intake Consent Form

ABC Plus
AMERICA'S Best Care PLUS, INC.
A Pharmacy Partner You Can Depend On

Form 1 of 2 to be completed

## Clinic Information

| Clinic ID | Clinic Name | | Telephone | Store Number |
|---|---|---|---|---|
| | America's Best Care Plus | | 256-997-1770 | |
| Address | | City | State | Zip |
| 1825 Everett Drive W | | Fort Payne | Alabama | 35968 |

## Patient Information

| Last Name | First Name | Date of Birth | Gender |
|---|---|---|---|
| | | | |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Primary Care Provider (PCP) Name | PCP Phone Number | PCP Fax Number |
|---|---|---|
| | | |

| PCP Address | City | State | Zip |
|---|---|---|---|
| | | | |

**Emergency Contact Information: Name**_____ **Phone Number:**_____

**Is this the patient's first ○ or second ○ dose of the COVID-19 vaccination?**

## Insurance Information: (For onsite clinics, please ensure a copy of the patient's insurance card(s) was collected)

*** INDICATES REQUIRED FIELDS**

**Prescription Insurance:** ○ Yes ○ No

*Are you the primary cardholder? *__If no__, include the primary cardholder's DOB

| *Prescription Benefit Plan Name | *Cardholder ID # | *RX Group ID | *BIN | *PCN |
|---|---|---|---|---|
| | | | | |

**Medicare Fields:**

○ Yes ○ No

*Is the Patient age 65 or older or Medicare Eligible?

*Medicare Part A/B ID Number (MBI) **Note:** *MBI is required for all patients age 65 and older, or Medicare eligible. Refer to your Medicare Red, White, and Blue card*

**Medical Insurance:**

| *Medical Insurance Provider | *Cardholder ID # | *Group ID | *Payer ID |
|---|---|---|---|
| | | | |

○ Yes ○ No

*Is the patient the 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 accurate:**

○ I I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government-funded health benefit plan.

In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, please provide either (a) a valid Social Security number, (b) state identification number and state of issuance, OR (c) a driver's license number and the state of issuance.

| *Social Security Number | or State Identification Number & State | or Driver's License Number & State |
|---|---|---|
| | | |

## Immunization Record Information *(Required)*

**Race:** ○ **1** - American Indian or Alaska Native ○ **2** - Asian ○ **3** - Native Hawaiian/Other Pacific Islander ○ **4** - Black or African American ○ **5** - White ○ **6** - Other Race

**Ethnicity:** ○ **1** - Hispanic ○ **2** - Not Hispanic or Latino ○ **3** - Unknown

Mother's Name (First and Last)

Father's Name (First and Last)

**CONTACT NUMBER TO SET UP 2nd DOSE:**_____

Last Name | First Name | Date of Birth

## Potential Contraindications

| | YES | NO | DON'T KNOW |
|---|---|---|---|
| 1. Are you feeling sick today? | ○ | ○ | ○ |
| 2. Have you ever received a dose of COVID-19 vaccine? | ○ | ○ | ○ |
| **If yes**, which vaccine product? ○ Pfizer ○ Moderna ○ Another product: _____ | | | |
| 3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) in the past? *Example: a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?* | ○ | ○ | ○ |
| Was the severe allergic reaction after receiving a COVID-19 vaccine? | ○ | ○ | ○ |
| Was the severe allergic reaction after receiving another vaccine or injectable medication? | ○ | ○ | ○ |
| Was the severe allergic reaction related to receiving Polyethylene Glycol or products containing Polyethylene Glycol? | ○ | ○ | ○ |
| Was the severe allergic reaction related to receiving Polysorbate or products containing Polysorbate? | ○ | ○ | ○ |
| 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

| | YES | NO | DON'T KNOW |
|---|---|---|---|
| 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 Sheet(s) or patient fact sheet corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request. State of Georgia only: I verify a pharmacist asked for my health history and whether I have had a physical exam within the past year. Health care providers did not identify condition(s) that would mean I should not receive vaccine(s).

**AUTHORIZATION TO REQUEST PAYMENT**: I do hereby authorize **America's Best Care Plus (ABC Plus)** to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid, or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

**DISCLOSURE OF RECORDS**: I understand that ABC Plus may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at ABC Plus (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that ABC Plus will use and disclose my health information as set forth in the ABC Plus Notice of Privacy Practices (copy is available in-store, online or by requesting a paper copy from the pharmacy). Vaccine Clinics: If I am receiving a vaccine through a vaccine clinic, I understand that my name, vaccine appointment date and time will be provided to the clinic coordinator.

**X** _____

**Signature of patient to receive vaccine (or parent, guardian, or authorized representative)** Date

*If signing on behalf of the patient, you are stating that you are authorized to provide the required consents on behalf of the patient.*

Name of parent, guardian, or authorized representative | Phone Number | Relationship

## Vaccine Administration Information for Immunizer/Pharmacist use only

| Administration Date | Vaccine | VIS Date | Manufacturer | Volume (mL) |
|---|---|---|---|---|
| | COVID-19 | 12/31/2020 | ○ L ○ R | |

| Lot # | Exp. Date | Route | Site |
|---|---|---|---|
| | | | |

**If patient's body temperature is 100.4˚F or greater, inform them they should not receive the vaccine at this time.**

**Patient Temperature**

Administering Immunizer Name & Title | Administering Immunizer Signature