CHET JOHNSON DRUG
Amery, Wisconsin

COVID-19 Vaccine Consent Form for 3rd Dose

Patient Information (Vaccine Recipient):

Name (Last)		**Date of Birth**	**Gender**	**Did you receive a previous COVID-19 vaccine at Chet's**	**YES** □ **NO** □
Name (First)		**Email Address:**			
Address					
City	**State**	**Zip**	**Phone Number**		

Screening Questions:

Question	YES	NO	Don't Know
1. Are you feeling sick today?	☐	☐	☐
2. What was manufacturer of your previous COVID-19 vaccine? ☐ Pfizer ☐ Moderna			
3. Have you ever had an allergic reaction to a previous dose of COVID-19 Vaccine (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	☐
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? *[note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]*	☐	☐	☐
5. Do you have a moderate to severe weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? **If YES, please explain:**	☐	☐	☐
6. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐

Consent (check each box below after reading and signing):

- ☐ I must present my COVID-19 VACCINATION RECORD CARD prior to receiving the 3rd vaccine.
- ☐ I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet, a copy of which I was provided with this Consent Form. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent Form.
- ☐ I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur.

If **insured**, please present your prescription and medical insurance cards and check the box below to attest:

- ☐ I authorize the pharmacy to bill my insurance on my behalf for the immunization – understanding I will not incur any costs.

If **uninsured**, check the boxes below to attest that the following information is true and accurate:

- ☐ I do not have any insurance, including but not limited to, Medicare, Medicaid, or any other private or government-funded benefit plan.
- ☐ I will present or provide: Social Security Number, State identification number and state of issuance and/or Driver's license number and state of issuance

This is needed in order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program.

Signature of Person to Receive Vaccine & EUA /VIS (or Signature of Parent/Guardian if Patient is < 18 years old):

Signature: _____Date: _____Patient Signature <18:_____

*****PHARMACY USE ONLY*****

Vaccine	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	☐ 3rd Dose	☐ IM - L Arm ☐ IM - R Arm		☐ Moderna ☐ Pfizer			

Pharmacist Name who reviewed this form: _____ **Pharmacist Signature**: _____

If **certified vaccinator** is different than the pharmacist who reviewed the form:

Name: _____ **Signature**: _____

Pharmacy Use for Insurance Information:

Social Security Number:

State ID number and State of Issuance:

Driver's License number and State:

Self-Attestation Form for COVID-19 Vaccination:
Moderately to Severely Immunocompromised Patients

CDC recommends that people who are moderately to severely immunocompromised receive an additional dose of an mRNA COVID-19 Vaccine (Pfizer-BioNTech or Moderna) at least 28 days after the completion of the initial mRNA COVID-19 vaccine series.

Patients may self-attest to their condition by completing and signing this form.

Please check one of the following and sign at the bottom.

Moderately to severely immunocompromised includes people who have:

____ Receiving active cancer treatment for tumors or cancers of the blood

____ Received an organ transplant and are taking medicine to suppress the immune system

____ Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system

____ Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)

____ Advanced or untreated HIV infection

____ Active treatment with high-dose corticosteroids (i.e., ≥20mg prednisone or equivalent per day for ≥ 14 days) or other drugs that may suppress your immune response [e.g., alkylating agents (cyclophosphamide); antimetabolites (methotrexate); transplant-related immunosuppressive drugs (cyclosporine, tacrolimus, everolimus); TNF-blockers (etanercept)]

____ Other condition(s) which cause moderate or severe immunosuppression similar to the above conditions

People should talk to their healthcare provider about their medical condition, and whether getting an additional dose is appropriate for them.

Printed Full Name: _____ Date: _____

Signature: _____