Discount Drug Mart COVID Vaccine Administration and Consent Form

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT) ALL SECTIONS MUST BE COMPLETED				
FIRST NAME:	**LAST NAME:**			**HOME ADDRESS COUNTY:**
ADDRESS:	**CITY:**		**STATE:**	**ZIP CODE:**
DATE OF BIRTH:	**AGE:**	**GENDER:**	**PHONE NUMBER:**	
ALLERGIES:		**CHRONIC ILLNESS:**		
PRIMARY CARE PHYSICIAN:	**ADDRESS:**		**PHONE NUMBER:**	
PARENT/GUARDIAN FIRST NAME:	**PARENT/GUARDIAN LAST NAME:**		**PARENT/GUARDIAN PHONE NUMBER:**	

RACE (CIRCLE ONE):

White **Black/African American** **Hispanic**

Asian **American Indian/Alaskan Native** **Prefer Not to Answer**

Native Hawaiian/Other Pacific Islander **Other**

ETHNICITY:

Are you of Hispanic, Latino, or Spanish origin? (SELECT ONE):

□ **Yes-Please specify:**_____

□ **No-Not Hispanic, Latino, or Spanish origin**

SCREENING QUESTIONNAIRE FOR IMMUNIZATIONS	YES	NO
1. Are you sick today?		
2. Do you have any allergies to medication, food, latex, yeast, neomycin, gelatin, or any vaccine component? Please list:		
3. Have you ever had a serious reaction after receiving a vaccine?		
4. During the past year, have you received a transfusion of blood or plasma or been given immune globulin?		
5. Are you pregnant, planning on becoming pregnant in the next month, or breast feeding?		
6. Have you had any vaccines administered to you in the past 14 days?		
7. Do you have asplenia or abnormal spleen function?		
8. Are you the recipient of an organ transplant or hematopoietic stem cell transplant?		
9. Do you have a history of Guillain-Barre syndrome (GBS)?		
10. Do you have a history of thrombocytopenia or thrombocytopenic purpura?		
11. Will you be traveling internationally in the near future?		
12. Are you a healthcare professional, college student, or work with the homeless?		
13. Are you currently taking any anti-viral medication or blood thinners?		
14. Have you ever received a COVID vaccine? If Yes, which manufacturer?		
15. Have you ever had a positive test for COVID-19 or been told that you have had COVID-19?		
16. Select the most appropriate Target Population/Occupation code on the second page.		

SIGNATURE AUTHORIZING VACCINATION: _____**DATE:** _____

[Person to receive vaccine or person authorized to make request (parent or legal guardian)]For **MEDICARE** or INSURANCE recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to Discount Drug Mart.

Physician on Record: Julia Bruner, MD MS 2500 MetroHealth Drive Cleveland, OH 44109

I have read or have had explained to me the information in the Vaccine Information Statement about the vaccine(s) I circled above. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or the person named above for whom I am authorized to make this request. I agree to receive treatment for any adverse event that may occur after receiving the vaccine(s) while on site. In the event of an accidental post vaccination needle stick to the vaccine administrator, I agree to be contacted for follow up lab work. I have received the EUA Form and the Discount Drug Mart NOPP.

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Place back tag here-do not cover signatures

Circle Dose, Manufacturer, and Admin Site

Dose: First Dose Second Dose

Manufacturer:

Pfizer/0.3ml Moderna/0.5ml Janssen/0.5ml

Administration Site: R Arm L Arm

Lot: **Exp Date:**

SCAN ADMIN FORM AND COPY OF INSURANCE CARD INTO PHARMACY SYSTEM. PLACE RX LABEL ON FORM-DO NOT COVER PERTINENT INFO. FILE IN RX FILES.

PLEASE CHECK ANY & ALL TARGET POPULATION/OCCUPATION CODES THAT APPLY:

	TPV1	Assisted Living Facility – Resident
	TPV2	Assisted Living Facility – Staff
	TPV3	Skilled Nursing Facility (RCF) – Resident
	TPV4	Skilled Nursing Facility (RCF) – Staff
	TPV5	State of Ohio DoDD Resident
	TPV6	State of Ohio DoDD Staff
	TPV7	State of Ohio Veterans Home Resident
	TPV8	State of Ohio Veterans Home Staff
	TPV9	State of Ohio MHAS Resident
	TPV10	State of Ohio MHAS Staff
	TPV11	State of Ohio DRC LTC residents
	TPV12	State of Ohio DRC LTC staff
	TPV13	Congregate Care Facility – Resident
	TPV14	Congregate Care Facility - Staff
	TPV15	Hospital worker – Clinical Staff
	TPV16	Hospital worker – Administrative Staff
	TPV17	Hospital worker– Ancillary Staff
	TPV18	Non-Hospital healthcare worker – Administrative Staff
	TPV19	Non-Hospital healthcare worker– Ancillary Staff
	TPV20	Non-Hospital healthcare worker – Clinical Staff
	TPV21	Emergency Medical Services (EMTs/Paramedics)
	TPV22	Individual with congenital disorder or early onset conditions (cerebral palsy; spina bifida; congenital heart disease; type 1 diabetes; inherited metabolic disorders; severe neurological disorders, including epilepsy; severe genetic disorders, including Down syndrome, fragile X syndrome, Prader-Willi syndrome, and Turner syndrome; severe lung disease, including cystic fibrosis and severe asthma; sickle cell anemia; and alpha and beta thalassemia) **WITH IDD** (intellectual or developmental disabilities)
	TPV23	Individual working in K-12 schools
	TPV24	Individual with congenital disorder or early onset conditions (see TPV22 for list of conditions) **WITHOUT IDD** (intellectual or developmental disabilities)
	TPV25	Diabetes Type 1
	TPV26	Pregnant
	TPV27	Bone Marrow Transplant Recipient
	TPV28	ALS
	TPV29	Childcare Services Worker
	TPV30	Funeral Services Worker
	TPV31	Law Enforcement, Corrections, Firefighter
	TPV32	Diabetes Type 2
	TPV33	End Stage Renal Disease
	TPV34	Cancer
	TPV35	Chronic Kidney Disease
	TPV36	Chronic Obstructive Pulmonary Disease
	TPV37	Heart Disease
	TPV38	Obesity
	TPV40	Individuals age 40 to 49 years of age
	TPV50	Individual age 50 to 59 years of age
	TPV60	Individual of 60 to 64 years of age
	TPV65	Individual over 65 years of age
	TPV70	Individual over 70 years of age
	TPV75	Individual over 75 years of age
	TPV80	Individual over 80 years of age
	TPVALL	Individuals age 12 to 39 years of age

Signature and Title of Vaccine Administrator:_____

Printed Name:_____ Date:_____