Patient Consent Form

Patient Information (Vaccine Recipient): **Clinic Location (circle): NEPS TPC Capital**

Name (Last) (first) (Initial)			**Email**	
Address		**Date of Birth**	**Age**	**Gender** ☐ **Male** ☐ **Female**
City	**State**	**Zip**	**Phone Number**	
Medicare ☐ **Yes** ☐ **No**	**Medicare #**			
Insurance Name		**ID #**		
Group		**BIN/PCN**	**Relation**	

Screening Questions:

Question	YES	NO	Don't Know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of the COVID-19 Vaccine? a. If yes, which vaccine product(s) did you receive? _____ b. If yes, how many doses of a Covid-19 vaccine have you received? _____ c. If yes, when was your last dose of a Covid-19 vaccine? _____	☐	☐	☐
3. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
4. Have you ever had an allergic reaction to any component of a Covid-19 vaccine such as Polyethylene Glycol (PEG) or Polysorbate	☐	☐	☐
5. Have you ever had an allergic reaction to a previous dose of a Covid-19 vaccine?	☐	☐	☐
6. Have you ever had an allergic reaction to another vaccine (other than Covid-19 vaccine)?	☐	☐	☐

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

☐ I understand the benefits and risks of the COVID-19 vaccine as described in the Vaccine Information Fact Sheet. 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 and that I am authorized to sign this Consent Form.

Signature of Person to Receive Vaccine (or Signature of Parent/Guardian/DPOA):

Signature:_____ **Date:** _____

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

Vaccine	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	☐ 1st Dose ☐ 2nd Dose ☐ Booster Dose	☐ IM - L Arm ☐ IM - R Arm		☐ Moderna ☐ Pfizer ☐ Johnson & Johnson			

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

Name: _____ **Signature**: _____