HERSHEY
Pharmacy & Gift Shop

Covid-19 (SARS-CoV-2)
Immunization Consent and Record

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	MI	GENDER
ADDRESS	CITY	STATE	ZIP
10-DIGIT PHONE NUMBER	BIRTHDATE (MM/DD/YYYY)	ALLERGIES	
PRIMARY CARE PHYSICIAN	PHYSICIAN'S ADDRESS	PHYSICIAN'S PHONE NUMBER	

VACCINE TO BE ADMINISTERED

- ☐ Pfizer and BioNTech **(1st vaccination)**
- ☐ Pfizer and BioNTech **(2nd vaccination)**
  Date of 1st vaccination: ____ /____ /_____ (DD/MM/YYYY)
- ☐ Moderna **(1st vaccination)**
- ☐ Moderna **(2nd vaccination)**
  Date of 1st vaccination: ____ /____ /____ (DD/MM/YYYY)
- ☐ Other:_____ **(1st vaccination)**
- ☐ Other:_____ **(2nd vaccination)**
  Date of 1st vaccination: ____ /____ /_____ (DD/MM/YYYY)

EMERGENCY USE AUTHORIZATION (EUA) FOR THE VACCINE

" I have been provided the Emergency Use Authorization (EAU) for the vaccine(s) I am consenting to receive. I have been given an opportunity to ask the pharmacist any questions or raise any concerns I have regarding vaccination, and those questions/concerns have been answered to my satisfaction. I understand there are benefits and risks to vaccines and I give my consent to receiving the requested vaccine(s) listed."

" I understand that while they can't be predicted, there are potential side effects of vaccines. These include but are not limited to, redness or soreness at injection site, swelling, fatigue, fever, malaise, flu-like symptoms, allergic reactions, infection, anaphylaxis, and rarely death. I release Hershey Pharmacy, Hershey Long Term Care and HersheyCare pharmacies, C&S Kray, affiliates, and employees from any claims, liabilities or other responsibility relating to injury, illness, death, or other loss related to the receipt of this vaccine. I acknowledge that the pharmacy requests and recommends that I remain in or around the waiting area for 20 minutes following immunization to observe for and triage adverse events or observed per facility protocol."

"I have received and reviewed a notice for privacy practices and acknowledge its contents. I understand that my primary care provider indicated on this form will be contacted per Pennsylvania regulations related to immunizations by a pharmacist. I understand the information may will be uploaded to the state immunization registry (PA-SIIS). I acknowledge that my insurance may not cover any or all of the cost of the vaccine, and I agree to pay the required copayment or cost prior to the administration being completed."

SIGNATURE/LEGAL GUARDIAN	PRINT NAME	DATE (DD/MM/YYYY)

PHARMACY USE ONLY

VACCINE : _____ ROUTE : _____ SITE : _____ LOT # _____

EXPIRATION : _____ EAU DATE : 12 / 2020 SIGNATURE : _____

RX LABEL AREA ONLY

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____