HERSHEY Pharmacy & Gift Shop

HERSHEYCARE Continuing Care Pharmacy

HERSHEY Long Term Care Pharmacy

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	

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 (MM/DD/YYYY) _____

☐ VERBAL AUTHORIZATION

AUTHORIZER NAME _____ RELATIONSHIP TO PATIENT _____ DATE (MM/DD/YYYY) _____

FACILITY REPRESENTATIVE _____

TO BE COMPLETED BY PHARMACIST ONLY

VACCINE ADMINISTRATION INFORMATION

VACCINE : _____ ROUTE : _____

EXPIRATION : _____ SITE : _____

EAU DATE : 12 / 2020 LOT # _____

SIGNATURE : _____

RX LABEL AREA ONLY

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Name _____

Age _____

	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 did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• Did you bring your vaccination record card or other documentation? *(yes/no)*	☐	☐	
3. Have you ever had an allergic reaction to: *(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 caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including either of the following: ○ Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
4. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

5. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ History of Guillain-Barré Syndrome (GBS)

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists