Oregon Healthcare PHARMACY SERVICES, INC.
1-866-LTCMEDS

CONSENT FOR COVID-19 VACCINATION UNDER EMERGENCY USE AUTHORIZATION

SITE NAME: _____ **DATE (MM/DD/YYYY):** _____/_____/_____

SECTION 1: INFORMATION ON PERSON RECEIVING VACCINE

Last Name (Please print)	First Name	MI
Date of Birth (MM/DD/YYYY)	**Age**	
Race ☐ Asian/Polynesian ☐ Black ☐ White ☐ Other ☐ Unknown	**Ethnicity** ☐ Non-Hispanic ☐ Hispanic ☐ Unknown	**Sex** ☐ Male ☐ Female ☐ Other
Address		**Apt**
City	**State**	**Zip**
Phone Number (____) ____-_____	**Email Address**	
Emergency Contact	**Relation**	**Phone Number**
Language Preference		
Occupation/Job Role	**Employer**	

SECTION 2: SCREENING QUESTIONS

1. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any vaccine or injectable therapy that required use of an EpiPen, or a history of anaphylaxis due to any cause?	YES	NO
2. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of a COVID-19 vaccine, including lipid nanoparticles or polyethylene glycol (PEG)?	YES	NO
3. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?	YES	NO
4. Are you under age 12?	YES	NO
5. For females, are you currently pregnant or breastfeeding?	YES	NO
6. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?	YES	NO
7. Do you have a bleeding disorder or are you taking a blood thinner?	YES	NO
8. Have you tested positive for COVID-19 in the last 10 days?	YES	NO
9. Are you currently in quarantine for COVID-19 exposure?	YES	NO
10. Have you been diagnosed with Multisystem Inflammatory Syndrome in adults or children in the last 90 days?	YES	NO
11. Have you ever been diagnosed with myocarditis (inflammation of the heart muscle) or pericarditis	YES	NO
12. If this is your second dose, when was the date of your first dose?	/ /	
13. If this is your second dose, which vaccine did you receive (Pfizer, Moderna, etc.)?		
14. Are you moderately to severely immunocompromised?	YES	NO
15. If this is your third dose or booster dose, when was the date of your second dose?	/ /	
16. If this is your third dose or booster dose, which vaccine did you receive (Pfizer, Moderna, etc.)?		

Please Continue to Section 3 on Next Page

SECTION 3: CONSENT FOR VACCINATION

I have read or had explained to me the Emergency Use Authorization (EUA) for the COVID-19 vaccine and understand the risks and benefits. I understand that the vaccinator will determine the type of COVID-19 vaccine to be given based on my responses to the questions and I certify that the information that I have provided above is accurate. I give consent to Oregon Healthcare Pharmacy Services, Inc., or its authorized agent to be vaccinated against COVID-19.

Signature of person being immunized or authorized representative

X _____

Relationship: _____ **Date**: _____/_____/_____

SECTION 4: INSURANCE INFORMATION

****COPY OF INSURANCE CARD IS ACCEPTABLE****

Non-Medicare	**Medical Card #**	**Medicare #**	**Individuals without Insurance**
Member ID # _____	_____	_____	**Please provide Social Security #**
RX BIN _____			_____
RX PCN _____			
RX GROUP _____			

SECTION 5: VACCINATION INFORMATION

FOR INTERNAL USE ONLY

Vaccine Manufacturer: ☐**Pfizer** ☐**Moderna** ☐**J&J(Janssen)**

Lot Number: _____

Expiration Date (MM/DD/YYYY): _____/_____/_____

EUA/VIS Date: _____

Vaccinator Initials: _____

Admin Date (MM/DD/YYYY): _____

Admin Site:

☐ Left Arm

☐ Right Arm