COVID-19 Vaccine Consent and Administration Record

Gwinnett Drugs
905 Parkside Walk Ln, Ste 108
Lawrenceville, GA 30043-7314
Phone: (770) 995-5911 Fax: (770) 995-5308

Name: ______________________ Male: ________ Female: ________ Date of Birth: ______________

Address: ______________________ City: ______________ State: __________ Zip: __________

Phone: ____________ Allergies: ______________________ Race: ______________

Primary Care Physician: ______________________ Office Phone Number: ______________________

Screening Questions

1. Are you sick today?	Yes	No
2. Do you have allergies to medications, food, eggs, yeast, a vaccine component, or latex?	Yes	No
3. Have you ever had a serious reaction after receiving a vaccination?	Yes	No
4. Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	Yes	No
5. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes) anemia or other blood disorder?	Yes	No
6. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, herpes, or cold sores?	Yes	No
7. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	Yes	No
8. In the past 4 weeks have you had any other vaccines? If yes, what was given & when: ______________________	Yes	No

Consent

I have read, or have had read to me, the written information regarding the vaccine(s) being administered. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and have received a copy of a current Vaccine Information Sheet. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Gwinnett Drugs, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s). I certify that I am at least 18 years old and hereby give my consent to the pharmacists of Gwinnett Drugs to administer the vaccine(s). If under 18 years old signature by parent or guardian is required. I agree to wait near the vaccination location for approximately 15 minutes for observation by the pharmacist.

HIPAA Privacy Information and Medical Records

1) I have acknowledged that I have received the providers Notice of Privacy Practices which may be provided at my request.
2) For Medicare, Medicaid, or Insurance Billing: I authorize this provider to release inforamtion and request payment. I understand that the information given by me in applying for payment is correct.
3) I authorize the release of all records to act on this request and I request that the paymetn of benefits be made on my behalf.

Name (print) ______________________ **Signature** ______________________ **Date** ______________

Insurance Information

Are you a facility resident? If yes, list facility name: ______________________ Room#: __________

Medical Insurance Payer: ______________________ Policy #: ______________ Group #: ______________

Prescription Drug Plan: RxBIN: __________ RxPCN: __________ Group #: __________ ID #: ______________

Administration (Pharmacist Use Only)

Vaccine	Dose	Manufacturer	Lot	Exp Date	Dose	Site of Injection	Date of VIS	Signature of Administrator of Vaccine
COVID-19	First Dose	Moderna			0.5 ml	LD RD	12/20/2020	
COVID-19	Second Dose	Moderna			0.5 ml	LD RD	12/20/2020	