

COVID-19 Vaccine Consent Form
Section 1: Patient/Employee Information

Kings Specialty Pharmacy 357 Flatbush ave, Brooklyn, NY 11238

NAME (Last)		(First)	DATE OF BIRTH	GENDER
ADDRESS				
CITY	STATE	ZIP	DAYTIME PHONE NUMBER	
PRIMARY CARE PHYSICIAN: Name		Address		Phone Number
EMERGENCY CONTACT: Name		Relation	Phone Number	

IS THIS YOUR FIRST • OR SECOND • DOSE OF THE COVID-19 VACCINE? If this is your second dose, what was the date of your first dose? _____ EMAIL ADRS _____

Section 2: Screening Questions

MEDICARE ID # _____

	YES	NO
1. Do you have any allergies? Please list:	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you sick today? (For example, cold, fever, or acute illness)	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have a bleeding disorder or are you on a blood thinner?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you immunocompromised or are you on a medicine that affects your immune system?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you pregnant or plan to become pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you received another COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
8. Current Pharmacy _____		

Section 3: Consent

• I have been given a copy and have read, or have had explained to me, the information in the **FACT SHEET** for the COVID-19 vaccine. I understand the FDA has authorized the emergency use of the COVID-19 vaccine, which is not an FDA-approved vaccine. I have had the chance to ask questions that were answered to my satisfaction.

• I understand the COVID-19 vaccine requires 2 doses given 4 weeks apart. If this is my first dose of the COVID-19 vaccine, I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the vaccination series.

• I understand the significant known and potential risks and benefits of the COVID-19 vaccine as explained in the FACT SHEET and that some potential risks and benefits may remain unknown, and **I REQUEST THE COVID-19 VACCINE BE GIVEN TO ME.**

• I agree to stay in the vaccine administration area for fifteen (15) minutes (or longer if indicated by the vaccine administrator) after receiving my vaccination to ensure that no immediate adverse reactions occur, and I understand that if I experience any adverse reaction, it will be my responsibility to follow up with my primary care physician.

SIGNATURE OF PATIENT / EMPLOYEE / LEGAL REPRESENTATIVE: _____

RELATIONSHIP TO PATIENT (if applicable) _____ DATE: _____

Section 4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	0.5 ml • 1 st ml • 2 nd	<input type="checkbox"/> IM - L Arm <input type="checkbox"/> IM - R Arm		Moderna			

• I VERIFY THAT I AM A HEALTHCARE WORKER. I CURRENTLY SERVE AS THE TITLE OF _____