FORM 1 - Perrone Pharmacy, Inc.
COVID-19 CONSENT AND RELEASE FORM

SECTION 1: PERSONAL INFORMATION – PLEASE PRINT CLEARLY (DO NOT USE NICKNAMES)

Last Name: First Name: Middle Name:

Address: Apt./Unit City:

State: Zip Code: County

Date of Birth: ____/____/_____(Month/Day/Year) Sex **(CIRCLE ONE):** M / F Race/Ethnicity (**REQUIRED**):

Phone: Email:

Social Security Number **(REQUIRED)**:_____

Mother's First Name **(REQUIRED)**:_____ Mother's Maiden Name **(REQUIRED):** _____

Do you have insurance? ☐Yes ☐ No **PLEASE NOTE:** The COVID-19 Vaccine is covered at no cost to you; however, depending upon your plan coverage, the vaccine administration claim may be billed to your medical benefit instead of pharmacy benefit.

If you have insurance, please bring these documents to copy: (1) your medical benefits card; (2) your prescription drug benefit card; (3) your Medicare supplement card; (4) your Medicare card (red, white & blue card) and (5) your driver's license, official photo ID or passport.

Emergency Contact **(REQUIRED)**: Emergency Contact Phone **(REQUIRED)**:

SECTION 2: COVID-19 VACCINATION INFORMATION/CHECKLIST– READ NOW & COMPLETE DAY OF VACCINATION

The ☐ Pfizer ☐ Moderna COVID-19 vaccine has been authorized by the Food and Drug Administration under an Emergency Use Authorization, or EUA, based on advice from the Secretary of Health and Human Services in response to the ongoing COVID-19 Pandemic. The COVID-19 vaccine has not been fully approved but is being made available under an EUA due to scientific evidence supporting the safety and efficacy of the COVID-19 vaccine and the vaccine's highly favorable risk-benefit ratio.

Perrone Pharmacy, Inc. is authorized to administer the ☐ Pfizer ☐ Moderna COVID-19 Vaccine based on guidance developed by the Centers for Disease Control and Prevention. In order to optimize vaccine response, you will receive 2 doses separated by ☐ 21 ☐ 28 days. Side effects reported in clinical trial of this vaccine include, but may not be limited to injection site pain, redness, or swelling, fatigue, headache, muscle pain, chills, fever, joint pain, nausea, or lymph node swelling. Such symptoms normally resolve within 24 hours and are typically mild but if severe should be reported to Perrone Pharmacy, Inc.

If severe allergic symptoms develop (trouble breathing, chest pain, fast heartbeat dizziness, weakness, facial, tongue, or throat swelling, or rash) after your observation period is complete, please call 911 or proceed to the nearest Hospital Emergency Department.

SCREENING CHECKLIST FOR TODAY'S IMMUNIZATION

1 Are you sick today? ☐ Yes ☐ No

2 Have you received any vaccinations in the last 14 days, or have you received any other COVID-19 vaccine previously? ☐ Yes ☐ No

3 Have you been diagnosed with COVID-19 infection within the last 90 days? ☐ Yes ☐ No

4 Have you ever had a reaction to any COVID-19 vaccine components (mRNA, several different lipid ingredients? ☐ Yes ☐ No

If you answered "Yes" to questions 1-4, we would advise you to postpone vaccination for COVID-19 as follows:

- If sick, wait until your symptoms have resolved. If you have tested COVID+, wait until 90 days have elapsed since positive COVID-19 test.
- Wait 2 weeks after other vaccinations to receive COVID-19 vaccination.
- You should not take the ☐ Pfizer ☐ Moderna COVID-19 vaccine if your first COVID-19 vaccine was produced by another manufacturer.
- If you have a history of anaphylaxis to any ingredient of the ☐ Pfizer ☐ Moderna vaccine, you CANNOT receive this vaccine based on current guidance.

5 Have you ever had a severe allergic reaction (anaphylactic) to a vaccine (including trouble breathing, hives, facial or tongue swelling, low blood pressure, fast heart rate) or other severe reaction to a vaccination? ☐ Yes ☐ No

6 Do you have a history of severe allergic reaction to anything besides a vaccine, including other medications, insect stings, or bites? ☐ Yes ☐ No

7 Do you take blood thinner or do you have a bleeding disorder? ☐ Yes ☐ No

If your answer to any of questions 5, 6 or 7 is "Yes", please notify the staff so that we can make the accommodations necessary to observe you more carefully following your vaccination., and if you have a bleeding tendency or are on blood thinners, we will watch you carefully for possible injection site bleeding.

8 Do you have a weakened immune system? ☐ Yes ☐ No

9 Are you now pregnant or might you become pregnant in the next 4 weeks, or are you breastfeeding? ☐ Yes ☐ No

If you answered "Yes" to questions 8 or 9, you can choose to be vaccinated but safety and efficacy data is still being collected for people in these groups.

10 Have you had COVID-19 in the last 90 days? ☐ Yes ☐ No

SECTION 3: CONSENT FOR VACCINATION AND BILLING INSURANCE

I have been provided with and have read the EUA Fact Sheet for the COVID-19 vaccine, the COVID-19 Vaccine Consent Form, and any additional information provided. I have had the opportunity for my questions to be answered by a medical professional, and I understand that a series of two vaccines will be required. I understand the known risks and benefits of vaccination and understand that not all risks may have yet been established. I know that I am consenting to this vaccine series under an EUA in response to the COVID-19 Pandemic. I request to proceed with vaccination. I understand Perrone Pharmacy, Inc. will use the information gathered to submit a claim to your insurance company for only the administration of the vaccine. I agree to remain on site for 15 minutes after vaccination and that my condition may warrant post vaccination observation for a least 30 minutes.

Date: **Time:** **Signature**

SECTION 4: THIS SECTION TO BE COMPLETED BY THE PHARMACY VACCINE ADMINISTRATOR:

Vaccine	Vaccine Info	Site	Manufacturer	Lot #	Expiration Date
COVID-19 Vaccine	Series ☐ 1st ☐ 2nd	Deltoid: ☐ Left ☐ Right	☐ Pfizer ☐Moderna ☐_____		

Date of Administration Vaccine Administrator Signature/Title or Credentials Location **Perrone Pharmacy, Inc.**