

FORM 1 - Perrone Pharmacy, Inc. COVID-19 Consent and Release Form

SECTION 1: PERSONAL INFORMATION – PLEASE PRINT CLEARLY AND 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) :

Telephone **(REQUIRED)**: _____

Social Security Number **(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 to your pharmacy benefit.

Please bring your (1) Photo ID (driver's license or passport); If you have insurance, (2) bring your medical benefits card; (3) your prescription drug benefit card, if it is a separate card from your medical benefit; (4) if on Medicare, your red, white and blue Medicare card; and (5) any Medicare Supplement insurance.

REQUIRED: Emergency Contact Name:	Emergency Contact Phone:
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SECTION 2: COVID-19 VACCINATION INFORMATION/CHECKLIST – READ NOW AND COMPLETE THE DAY OF YOUR 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2 Have you received any vaccinations in the last 14 days, or have you received any other COVID-19 vaccine previously?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3 Have you been diagnosed with COVID-19 infection within the last 90 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4 Have you ever had a reaction to any COVID-19 vaccine components (mRNA, several different lipid ingredients)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 are 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6 Do you have a history of severe allergic reaction to anything besides a vaccine, including other medications, insect stings, or bites?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7 Do you take blood thinner or do you have a bleeding disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9 Are you now pregnant or might you become pregnant in the next 4 weeks, or are you breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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.

NOTE: IF PERSON BEING VACCINATED IS UNDER 18 YEARS OF AGE, A PARENT OR GUARDIAN MUST SIGN BELOW.

Date:	Time:	Relationship to Patient: <input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN
Print Name:	Signature:	

THIS SECTION TO BE COMPLETED BY THE ADMINISTRATOR:

<u>Vaccine</u>	<u>Vaccine Info</u>	<u>Site</u>	<u>Manufacturer</u>	<u>Lot #</u>	<u>Expiration Date</u>
COVID-19 Vaccine	Series <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd	Deltoid: <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> _____		
Date of Administration	Vaccine Administrator Signature/Title or Credentials		Location	Perrone Pharmacy, Inc.	