## Please read this form in its entirety.

Please keep in mind we are currently trying to vaccinate the most vulnerable phase 1a patients in the community first.

## The Medicine Shoppe Pharmacy COVID-19 First Dose Vaccination for Residents of the Boyertown Area

This form is HIPAA compliant and protects the integrity of your Protected Health Information. This scheduling tool is intended only for those individuals that qualify for Phase 1a. Please read this form in its entirety. If you have ANY issues completing this form, please do not submit twice.

Ensure registrants know their info is protected

## Please do not show up to an appointment without BOTH your prescription insurance card and your medical insurance card. If possible, please bring photocopies of your cards to expedite the process.

If you are on a Medicare Advantage plan, we still require your Medicare Part B (red, white, and blue card). If you do not have your insurance cards, we cannot vaccinate you. We want to emphasize that the immunization is no charge to you, but insurance is needed for our records.

Vaccine Recipient Name: *

First Name | Middle Name | Last Name

Vaccine Recipient Address: *

Street Address

Street Address Line 2

City | PA State

Zip Code

Please Select

Country

Email: *

example@example.com

We eliminated the org code but you are encouraged to use a single organization email address here, for confirmation emails

Date of Birth: *

MM-DD-YYYY

Date

Phone Number: *

(000) 000-0000

Enter the patient phone number

Sex *

- F
- M

Race *

Please Select

This question is required by the state and is asked for research purposes.

Do you have any medication or food allergies? *

- No known drug or food allergies
- Yes

Don't need seasonal allergies, need food/drug allergies

If you selected yes, please list your allergies and describe the reaction to the medication/food.

example - hives, throat swelling, anaphylaxis

Do you have means of transportation to get to the clinic? *

- Yes
- No

If you answer no, a home visit will be scheduled at a later date

Do you need wheelchair assistance? *

- No
- Yes

Please check all that apply to you: *

- Long-term care facility resident
- Health care personnel
- 65 years old and older
- 16-64 years old with an eligible high-risk condition
- Teacher
- Other school staff
- None of the above

# Congratulations! You are applicable for the COVID-19 Vaccine.

Please complete this form prior to your appointment

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# COVID-19 Immunization Consent Form

Please complete this form prior to your appointment

## Screening Questions

Please complete the following questions. We will ask you some of these questions at the time of your vaccine to confirm your answers.

Are you sick today? (We will re-ask this question prior to your vaccine) *

- ◯ Yes
- ◯ No
- ◯ Not sure

Patients who are actively ill cannot be vaccinated

Have you ever received a dose of the COVID-19 vaccine?

- ◯ Yes
- ◯ No
- ◯ Not sure

If they say 'yes', do not complete the registration. They have to get their second dose where they got the first

Are you allergic to polyethylene glycol, polysorbate, or a previous dose of COVID-19 vaccine? *

- ◯ Yes
- ◯ No
- ◯ Not sure

Polyethylene glycol = active ingredient in Miralax
Polysorbate = ingredient in things like ice cream, pudding

Have you ever had an anaphylactic allergic reaction that required you to use an EpiPen (epinephrine) or go to the hospital? *

- ◯ Yes (you will have to be observed for 30 minutes post-vaccination)
- ◯ No
- ◯ Not sure

If yes, they need to be monitored for 30 minutes post-vaccine instead of 15 minutes

Have you received ANY vaccine in the last 14 days? *

Have you received ANY vaccine in the last 14 days? *

- Yes
- No
- Not sure

Recipients cannot get the COVID vaccine if they answer 'yes'. COVID vaccines have not been studied with other vaccines

If you selected yes to the above statement, please select the date of your most recent vaccine

MM-DD-YYYY

The COVID vaccine cannot be given within 14 days of any other vaccine.

Have you ever tested positive for COVID-19? *

- Yes
- No
- Not sure

If the answer to this question is 'yes', patients can and should get the vaccine. This question is for research purposes.

In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure? *

- Yes (please wait until after your quarantine to become vaccinated)
- No
- Not sure

If you have had COVID-19, have you received a transfusion of passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 in the past 90 days?

- Yes
- No
- Not sure

If you selected yes to the above statement, please select the date of your last transfusion or monoclonal antibody treatment for COVID.

MM-DD-YYYY

It is not recommended to get the COVID vaccine until 90 days after treatment.

Do you have a weakened immune system, autoimmune disease, cancer, and/ or do you take immunosuppressive drugs or therapies? *

- Yes
- No
- Not sure

It is not recommended to get the COVID vaccine until 90 days after treatment.

Do you have a weakened immune system, autoimmune disease, cancer, and/ or do you take immunosuppressive drugs or therapies? *

- Yes
- No
- Not sure

If the answer to this question is 'yes' patients can still get the vaccine. This question is for research purposes.

Do you have a bleeding disorder or are you taking a blood thinner? *

- Yes
- No
- Not sure

If the answer to this question is 'yes' patients can still get the vaccine. This question is for research purposes.

Are you pregnant or breastfeeding? *

- Yes
- No
- Not sure

If the answer to this question is 'yes' patients can still get the vaccine. This question is for research purposes.

Vaccine Eligibility:

Eligible

If this field says 'eligible,' the recipient may come to the clinic. If this field says 'NOT eligible' the recipient cannot come to the clinic. Please call the pharmacy to see when/if the recipient is eligible.

Please acknowledge that you read the following statement. I, the vaccine recipient, agree to wear a mask during vaccine administration. I agree to get my temperature taken before administration and that if my temperature exceeds 98.6F, my appointment may be rescheduled for the safety of myself and others. I WILL NOT PRE-medicate with analgesics (Advil, Tylenol, Motrin, etc.) to try to reduce post-vaccine administration side effects. I understand that if I take any of these agents beforehand, it may reduce the effectiveness of my vaccine. *

- [ ] I acknowledge and agree to the above statements.

Make sure they understand that they should not take Tylenol/Advil before taking the vaccine, unless directed by a doctor - they may reduce vaccine efficacy. It is ok to take them after the shot.

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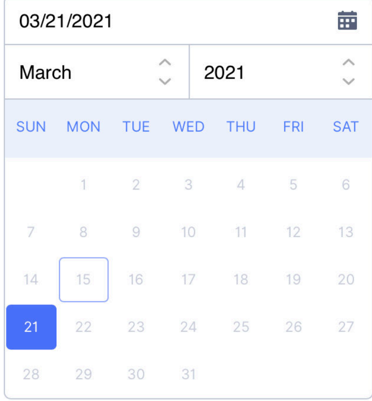
## Scheduling Tool

Please do not schedule an appointment if you are not eligible for the vaccine. Please keep in mind you will have to be observed for 15-30 minutes post-vaccination.

DO NOT SCHEDULE AN APPT IF THE PERSON IS NOT ELIGIBLE

Clinic Availability *



Sunday, March 21

2:30 PM | 2:45 PM | 3:00 PM | 3:15 PM

America/New_York (GMT-04:00)

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## Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). Please click the following website for more information: https://www.fda.gov/media/144638/download. For volunteers: Please point patients to where they can access more information on our website. If patients do not have computer access, ensure them that they can receive a copy at the time of vaccination.

medicineshoppeboyertown.com

## Consent to Vaccination

I have read, or have had read to me, the written information regarding the COVID-19 vaccine 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 being administered and have received a copy of a current COVID Vaccine Fact Sheet. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless The Medicine Shoppe Pharmacy, 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 this Pharmacy 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. I have read and reviewed the Notice of Privacy Practices available at www.medicineshoppeboyertown.com.

Form completed by * Volunteer's name

First Name

Last Name

Signature of Person Receiving the Immunization (or Parent/Guardian of person < 18 years old)

Sign Here

Clear

Ok for volunteer to sign - we will have the patient sign at the time of vaccination

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## Submit

Please review your answers and submit.

### If the submit button is not visible to you, you are not eligible for the vaccine at this time.

### Please do not show up to an appointment without BOTH your prescription insurance card and your medical insurance card, preferably photocopies.

Even if you are on a Medicare Advantage plan, we still require your Medicare Part B (red, white, and blue card). If you do not have your insurance cards, we cannot vaccinate you. We want to emphasize that the immunization is no charge to you, but insurance is needed for our records.

This is EXTREMELY important. Patients may claim they do not use Medicare and use a Medicare Advantage plan instead. It does not matter, we need this part B card. We cannot vaccinate them if they don't have this card

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Review Answers

You must review before you submit