Vaccine Administration Consent Form

Brookshire Grocery Company (rev 9/1/2022)

SARS CoV-2 Vaccine (Covid-19)

Patient Information

Patient Name	Sex ☐ Female ☐ Male	Phone	Date of Birth
Address	City	State	Zip Code
Arm Preference ☐ Right ☐ Left			
Race ☐ Asian ☐ Pacific Islander ☐ White ☐ Black ☐ Native American ☐ Other	Ethnicity ☐ Hispanic or Latino ☐ NOT Hispanic or Latino	Covid Vaccine Dose # ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th	Is this a Booster Dose? ☐ Yes ☐ No
Primary Doctor	Conditions Check all that apply ☐ Chronic Lung Disease ☐ Heart Condition ☐ Severe Obesity ☐ Diabetes ☐ CKD (w/dialysis) ☐ Liver Disease ☐ Immunocompromised ☐ Other		
County/Parish of Residence	Which shot are you requesting? ☐ Pfizer ☐ Moderna ☐ Janssen ☐ Novavax	Would you also like to get your flu shot today? ☐ Yes ☐ No ☐ Already received it	

Questionnaire

☐ Temperature (To be added by pharmacy staff at time of administration)

☐ Yes ☐ No Do you have a fever or have you felt feverish recently, new or unexplained cough, shortness of breath or difficulty breathing, chills, unexplained muscle pain, recent onset of headache or sore throat?

☐ Yes ☐ No Do you have any other flu-like symptoms or loss of taste or smell?

☐ Yes ☐ No Have you experienced any recent GI upset or diarrhea?

☐ Yes ☐ No Are you in contact with anyone who has been confirmed to be COVID-19 positive?

☐ Yes ☐ No Have you tested positive for COVID-19 in the past 14 days or are currently waiting for results?

☐ Yes ☐ No Do you have any allergies to eggs, gelatin, neomycin, latex, other medications, or vaccines?

☐ Yes ☐ No Have you ever had a serious reaction after receiving a vaccination? (hives, trouble breathing, etc.)

☐ Yes ☐ No Do you have cancer, leukemia, HIV/AIDS, bone marrow disease or any other immune system problems?

☐ Yes ☐ No In the past 3 months, have you taken medications or therapy that weaken your immune system? (i.e., steroids, anticancer drugs, radiation therapy)

☐ Yes ☐ No Have you had a seizure or other nervous system problem after a vaccine such as Guillian-Barre Syndrome?

☐ Yes ☐ No Have you had any vaccinations in the past 4 weeks?

☐ Yes ☐ No For women: Are you pregnant or is there a chance you could become pregnant in the next month?

INFORMATION FOR THE PERSON TO RECEIVE THE VACCINE:

I agree that the person named above will receive the vaccine indicated and that this person will have a vaccine administered by injection to prevent infectious disease. I acknowledge that I received a current copy of the Emergency Use Authorization Fact Sheet for this vaccine and have had the opportunity to ask questions concerning the benefits and risks of the vaccine and the diseases it prevents. **I understand that the person named above will be asked to stay near the pharmacy or clinic at least 15 minutes after the vaccine has been administered to ensure that no adverse reactions will occur.** I acknowledge that I currently meet the requirements to receive the Covid vaccine in the state that it is being administered. I freely and voluntarily authorize the administration of these vaccines to me or the person named above for whom I am authorized to make this decision.

By signing this form, I authorize the release of any medical or other information necessary to process this claim. I also request and authorize the payment of government benefits to the party who accepts assignment. My signature will also confirm my acknowledgement of receiving a copy of Brookshire Grocery Company (BGC) Notice of Privacy Practices. If I decide to leave less than 15 minutes after the vaccine has been administered, my signature indicates that I will not hold any BGC employee liable for any adverse reaction that may occur outside of their supervision. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); the subsidiaries and affiliates of the pharmacy,the respective directors, officers, employees, and agents of the pharmacy and its subsidiaries and affiliates, and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability that might arise from this vaccination.

Signature of Patient or Parent/Legal Guardian (if under 18) X _____

For Pharmacy Use Only

Vaccine	Dose	Route	Lot	Expiration Date	Site	Dose
Pfizer Vaccine(12+ years)-Gray	0.3 mL	IM			☐ RD ☐ LD	☐ 1 ☐ 2 ☐ 3
Pfizer Vaccine(5-11 years)-Orange	0.2 mL	IM			☐ RD ☐ LD	☐ 1 ☐ 2 ☐ 3 ☐ 4
✳Pfizer **BIVALENT** Booster(18+)-Gray	0.3 mL	IM			☐ RD ☐ LD	☐ 3 ☐ 4 ☐ 5 ☐ 6
Moderna Vaccine(12+ years)-Red	0.5 mL	IM			☐ RD ☐ LD	☐ 1 ☐ 2 ☐ 3
Moderna Vaccine (6-11 years)-Blue	0.5 mL	IM			☐ RD ☐ LD	☐ 1 ☐ 2 ☐ 3
✳Moderna **BIVALENT** Booster(18+)-Blue	0.5 mL	IM			☐ RD ☐ LD	☐ 3 ☐ 4 ☐ 5 ☐ 6
Janssen Covid-19 Vaccine	0.5 mL	IM			☐ RD ☐ LD	☐ 1 ☐ 2
Novavax Covid-19 Vaccine	0.5 mL	IM			☐ RD ☐ LD	☐ 1 ☐ 2
Influenza ☐ FZ HD ☐ Flublok ☐ Fluarix ☐ FZ Quad ☐ Flulaval	☐ 0.5 mL ☐ 0.7 mL	IM			☐ RD ☐ LD	

Pharmacist Printed Name

Pharmacist Signature Date

Technician/Intern Signature (If applicable) Date

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