



Informed Consent for the COVID-19 Vaccination Additional Dose/Booster



SECTION A Information About Individual to Receive the COVID-19 Vaccination Additional Dose/Booster (please print clearly)

Vaccine Recipient Information

First name: _____ M.I.: _____
Date of birth: _____ Age: _____
Home address: _____
Facility Name: _____

Resident Facility Staff
Last Name: _____
Gender: Female Male Phone: _____
City: _____ State: _____ Zip Code: _____
County: _____

Power of Attorney (POA)/Legal Guardian Information (if applicable)

First name: _____ M.I.: _____ Last Name: _____

Primary Care Provider Information

- My Primary Care Provider is the facility's medical director.
- I have an established relationship with a Primary Care Provider.
- I do not have a Primary Care Provider.

Medical Director's Name: _____
Primary Care Provider's Name: _____

Billing Information Provide copies of insurance cards (if applicable)

- Medicare Medicare Number: _____
- Private Insurance Plan Name: _____
Group: _____ BIN: _____

NO Insurance
Social Security Number: _____
ID Number: _____
PCN: _____

SECTION B Screening for Vaccine Eligibility

1. Have you completed the primary COVID-19 vaccine series? If yes, complete the information below. Vaccine Brand (i.e. Pfizer, Moderna, etc.): _____ Date Dose #1 Given (Month/Day/Year): _____ Date Dose #2 Given (Month/Day/Year): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
2. Do you meet the clinical considerations to receive an additional dose/booster? (i.e. moderately or severely immunocompromised including but not limited to: active treatment for malignancies, stem cell/organ transplant, HIV, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
3. In the past two weeks, have you received any other vaccine(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
4. Do you feel sick today?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
5. Do you have allergies to latex, oral or injectable medications, food, or vaccines? (If yes, list your allergies): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
6. Have you ever had a severe allergic reaction (i.e. anaphylaxis) after receiving a vaccination or injectable therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
7. For women: Are you pregnant, possibly pregnant, or considering becoming pregnant in the next month?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

SECTION C Consent

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to Absolute Pharmacy and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the COVID-19 vaccine. I understand that it is not possible to predict all possible side effects or complications associated with receiving the COVID-19 vaccine. I understand the risks and benefits associated with the COVID-19 vaccine and have received, read and/or had explained to me the Vaccine Information Statement and/or the Emergency Use Authorization fact sheet. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for observation for the time specified by the applicable Provider after administration. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the COVID-19 vaccine.

I GIVE CONSENT to the applicable Provider for the individual named in Section A to be vaccinated with the COVID-19 vaccine.

I DO NOT GIVE CONSENT to the applicable Provider for the individual named in Section A to be vaccinated.

Individual Signature, Signature of POA, or Printed Name of POA/verbally acknowledged by licensed facility staff (sign/print name and credentials):

X

Date: _____



Vaccine Administration Record - COVID-19 Vaccination Additional Dose/Booster



Vaccine Recipient Information

Resident Facility Staff

First name: _____ M.I.: _____ Last Name: _____

HEALTHCARE PROVIDER USE ONLY BELOW THIS LINE

Clinic/Pharmacy Name: Absolute Pharmacy
Address: 7167 Keck Park Circle, North Canton, OH 44720
NPI: 1396719076

SECTION D Complete DURING Vaccine Administration – Dose 3

- 1. I have reviewed the **Vaccine Recipient Information** and **Screening Questions** with the patient. Initial here: _____
- 2. I have verified whether the person is a **resident or staff member** of the facility. Initial here: _____
- 3. I have confirmed this individual is **eligible to receive** an additional dose/booster. Initial here: _____
- 4. I have verified **primary series completion** and acknowledge due diligence in determining which mRNA vaccine should be administered for the additional dose/booster. Initial here: _____
- 5. I have verified the **Vaccine NDC** matches the NDC on the bottom of this VAR. Initial here: _____
- 6. I have provided the patient with the **Emergency Use Authorization Fact Sheet** or **Vaccine Information Statement** and **counseling**, as applicable. Initial here: _____
- 7. I have provided the patient with a completed **COVID-19 Vaccination Record Card**. Initial here: _____

Vaccine Information & Dose/Route Given: <input type="checkbox"/> Pfizer COVID-19 NDC: 59267-1000-01 0.3 mL/IM <input type="checkbox"/> Moderna COVID-19 NDC: 80777-0273-99 0.5 mL/IM <input type="checkbox"/> Janssen COVID-19 NDC: 59676-0580-15 0.5 mL/IM <input type="checkbox"/> Other _____	Lot: Expiration:
	Injection Site: L Arm R Arm Needle Gauge/Length: 25G 1in 25G 5/8 in Other: _____
Vaccine Administrator Printed Name/Title:	Vaccine Administrator Signature:
Notes:	Date Administered: