

**COVID-19 VACCINE SCREENING AND CONSENT FORM Moderna/Pfizer/J&J Vaccine**

**Hometown Drugs**

16819 S. Dupont Hwy, Ste 600, Harrington, DE 19952  
Ph: 302 450 1970 Fax: 302 450 1971

Name: First: _____ Last: _____ Middle initial: _____ DOB: __/__/____	
Address: _____ City _____ State: _____ Zip: _____	
Phone: Cell _____ Home _____	
Insurance Details: _____ 1 <sup>st</sup> / 2 <sup>nd</sup> Dose _____	
<b>Sex</b>	<b>Race</b>
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other <input type="checkbox"/> Other Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other Nonwhite <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Other Pacific Islander
<b>Ethnicity</b>	
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	

**SECTION 2: COVID-19 SCREENING QUESTIONS**

Please check YES or No for each question.	Yes	No
1. Do you have today or have you had at any time in the last 10 days a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?		
2. Have you tested positive for and/or been diagnosed with COVID-19 infection within the last 10 days?		
3. Have you had a severe allergic reaction (e.g. needed epinephrine or hospital care) to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
4. Have you had any other vaccinations in the last 14 days (e.g. influenza vaccine, etc.)?		
5. Have you had any COVID-19 Antibody therapy within the last 90 days (e.g. Regeneron, Bamlanivimab, COVID Convalescent Plasma, etc.)		

**Please check YES or No for each question.**

Please check YES or No for each question.	Yes	No
6. Do you carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, foods, vaccines or latex?		
7. For women, are you pregnant or is there a chance you could become pregnant?		
8. For women, are you currently breastfeeding?		
9. Are you immunocompromised or on a medication that affects your immune system?		
10. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
11. Have you received a previous dose of any COVID-19 vaccine?		
If yes, which manufacturer's vaccine did you receive: _____		

- I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to Hometown Drugs or its associates to administer the COVID-19 vaccine.
- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.

- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes** (or more in specific cases) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Hometown Drugs and their staffs, agents, 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 vaccine listed above.
- I acknowledge that: (a) I understand the purposes/benefits of Delaware State immunization registry and (b) Hometown Drugs will include my personal immunization information in DelVAX and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize Hometown Drugs to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to Hometown Drugs with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if Hometown Drugs invoices me after the time of service, upon receipt of such invoice
- I acknowledge receipt of the Notice of Privacy Rights.

**Signature of Patient or Parent/Guardian of Minor Patient** \_\_\_\_\_ **Date:** \_\_/\_\_/\_\_

**Print Name of Representative and Relationship to Person Receiving Vaccine:** \_\_\_\_\_

**For Vaccinator Only:**

Vaccine Name	Manufacture	Lot	Expiration Date	Site	Date of EUA Fact Sheet
Moderna Covid 19 Vaccine	Moderna			RD LD	

**Vaccinator Print Name:** Rahul Patel **Signature:** \_\_\_\_\_ **Date:** \_\_/\_\_/\_\_