FRESCO y Más +PHARMACY FARMACIA | HARVEYS +PHARMACY | Winn-Dixie +Pharmacy

_____ Current Temperature

COVID-19 Consent Form

First Name:_____Middle Name:_____Last Name:_____Date of Birth:___/___/____

Address:_____City:_____State:_____Zip:_____

Phone: (___)_____Primary Care Physician: _____Vaccine: COVID-19

Insurance information:_____ Sex: ☐ Male ☐ Female

Race: ☐ Asian ☐ Black ☐ American Indian ☐ White ☐ Other S S N / D L # :_____

Please answer the following questions to determine if you are eligible for a vaccine. If you have any questions please ask a pharmacist.

	COVID-19 Vaccine Questionnaire	Yes	No
1	Do you feel sick today?		
2	Have you ever had a bad reaction to a vaccine including feeling dizzy or fainting?		
3	Do you have chronic health conditions such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorder?		
4	Do you have cancer, leukemia, HIV/AIDS or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohn's disease?		
5	Do you have allergies to latex, medications, food or vaccines? (eggs, gelatin, neomycin, polymixin or thimerosal, polyethylene glycol). If yes, please list _____		
6	Have you ever had a seizure disorder, brain disorder (including Guillian Barre) or any other nervous system disorders?		
7	In the past 3 months have you taken medications that weaken the immune system such as cortisone, prednisone, other steroids or anticancer drugs, or have you had radiation treatments?		
8	Have you ever received a pneumonia vaccine?		
9	Have you ever received a tetanus and whooping cough booster?		
10	**For Tdap and adult Td (ONLY):** Do you have an open wound, puncture or tissue tear that prompted you to get a tetanus shot?		
11	**For women**: are you pregnant or considering becoming pregnant in the next month?		
12	**If you are 5 – 17 years old**: are you taking aspirin or any aspirin containing products?		
13	Has any physician or healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a physician's office or hospital?		
14.	Have you had any vaccines in the last 14 days		

I acknowledge that I have received, read and understand the Vaccine information Statement for the vaccines(s) below. I have had the chance to ask questions about the contents of the Vaccine Information Statement. I understand the benefits and risks of the vaccine, and I believe that benefits of receiving the vaccine outweigh the risks associated with receiving the vaccine. I hereby consent to have the vaccine administered to me by the company pharmacist. I understand and agree that this company may be required by applicable law to report certain information without notice to me about my vaccinations to the appropriate state and federal regulatory authorities for purposed such as reporting of adverse events or immunization registries. I further agree to hold harmless BI-LO, LLC and its subsidiaries, officers, employees, agents, representatives, contractors, successors and assignees from any claim or action arising out of or, in any way incidental to this vaccination. I am 18 years or older, under no duress, and have read and understand this informed consent for the vaccine listed below. I will communicate the information provided to me today about my vaccination to my primary care provider, if I have one. I also understand that i should wait in store for a 15 minute observation period after receiving my vaccine. Additionally, by signing below I attest that I qualify to receive vaccine based on my state health jurisdictions guidelines/eligibility requirements.

_____ _____ _____

Print Name Signature of Patient or Legal Guardian Date

Admin Date	Vaccine	Lot #	Exp Date	Manufacturer	Dosage	Site of Injection	EUA Date	Date MD Notified
						IM/SQ L/R Deltoid		
						IM/SQ L/R Deltoid		
						IM/SQ L/R Deltoid		

Signature administering Pharmacy staff _____Supervising Pharmacist_____

☐ For Children ages 3 – 17. I attest I informed patient or adult caregiver of the importance of pediatrician wellness checks.