Kevin's Shop n Save Pharmacy
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Pittsburgh Pa 15234
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Fax: 412-561-7418

Blue Cross	Medicare
Aetna	UPMC
Gateway	United HC
Geisinger	PA H&W
Humana	_____

COVID-19 Immunization Consent Form

Section 1: Information about Patient to Receive COVID-19 Vaccine (*please print*) *ALL FIELDS REQUIRED

PATIENT'S NAME (Last)	**(First)**	**DATE OF BIRTH** MONTH__ __ DAY__ __ YEAR__ __ __	
ADDRESS		**AGE**	**GENDER** M / F
CITY		**STATE**	**ZIP**
ETHINICITY (PLEASE CIRCLE) Asian Black/African American Hispanic/Latino White Other	**CELL PHONE**	**EMAIL**	

The following questions will help us to know if you are eligible to receive the COVID-19 vaccine today.
Please check YES or NO for each question. DOSE #_____

	YES	NO
1. Are you feeling sick today?		
2. Have you ever received a dose of any COVID-19 vaccine? If so, which product? Pfizer Moderna Other		
3. Do you have any allergies to medications, foods, latex, or vaccine component?		
4. Have you ever had severe allergic reaction (i.e anaphylaxis)? For example, a reaction for which you were treated with an EpiPen (epinephrine) or for which you had to go to a hospital? Was the severe allergic reaction from— A previous COVID-19 vaccine? Another vaccine, injectable medication, or shellfish?		
5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19?		
6. Have you received another vaccine in the last 14 days?		
7. Have you had a positive test for COIVD-19 or has a doctor ever told you that you had COIVD-19		
8. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?		
9. Do you have a bleeding disorder or are you taking a blood thinner?		
10. Are you pregnant or breastfeeding?		

Patient Signature (DOSE #_____)_____Date:_____/____/_____
Screening Questions reviewed by:_____

Section 3: Patient Consent

I have read or had explained to me the current Vaccine Information Statement (EUA) for the COVID-19 vaccine and understand the risks and benefits.

I DO GIVE CONSENT— By Signing below, I give consent to Pleasant Hills Apothecary and it's staff, to vaccinate myself with the COVID-19 vaccine series, dose 1 followed 28 days later by does 2, and to report any data collected on this form to the required State and/or Federal agencies as required (if this consent form is not signed, then the patient will not be vaccinated).

I also agree to hold harmless Pleasant Hills Apothecary its directors, officers, employees, agents and stockholders from and against all claims, demands, actions, suits, damages, liabilities, losses, settlements, judgements, costs and expenses (including but limited to reasonable attorney fees and costs), whether or not involving a third-party claim, which may arise out of, or relate to, the administration of this vaccine.

Patient Signature (Dose #_____)_____Date:____/____/_____

Section 4: Insurance Information

Please fill out if not providing insurance card.

Prescription Insurance Information
Insurer:_____
ID:_____
RX Group:_____
RX BIN:_____
RX PCN:_____

Medical Insurance Information
Insurer:_____
ID:_____
Group:_____
Medicare ID*:_____
*Requires Red, White and Blue Card

Pharmacy Use Only

Section 5: Vaccination Record

Vaccine	Dose	Route (I.M) Deltoid	Date Dose Administered	Vaccine Manufacturer	Lot/Exp
COVID-19	1-2-3-4 5-6-7-8 9-10-11-12	Left Right	___/___/___	Moderna Novavax Pfizer Pfizer Pediatric	/

Pharmacist:

Kevin Evancic (NPI: 1417958539) Signature:_____
Luke Taylor (NPI: 1730776006) Signature:_____
Tom Tritinger (NPI: 1932225042) Signature:_____
Lauren Simko (NPI : 1598880882) Signature:_____
_____NPI:_____ Signature:_____