COVID-19 Vaccine Intake Form – Stauffer's Drug Store

All information is protected under HIPAA privacy regulations.

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

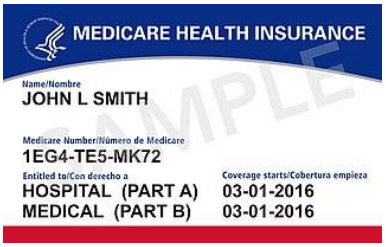
Phone: (_____)_____ Date of Birth: _____

Social Security Number: _____

1. **Are you Medicare Eligible?** ☐ Yes ☐ No

If Yes –> <u>require copy of Medicare card</u> (see sample picture)

Examples: Born 1956 or earlier or younger with disability



2. **Do you have Medicaid, Tricare, or Employer Insurance?** ☐ Yes ☐ No

If Yes -> require copy of Pharmacy/Prescription insurance card

Note: Pharmacy card should contain an ID#, BIN#, PCN# and Group#

3. **Are you Uninsured?** ☐ Yes ☐ No

COVID Screening & Consent Form -Bivalent Boosters **Stauffer's Drug Store**

Patient Name: **DOB:** **Preference:** ☐ Left Arm ☐ Right Arm **Race:** ☐ White ☐ Black/African Amer ☐ Asian ☐ Hispanic/Latino ☐ Other **Sex:** ☐ M ☐ F			
Receiving Today: ☐ Moderna Bivalent Booster ☐ Pfizer Bivalent Booster ☐ Other: _____	**Yes**	**No**	**Don't Know**
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Novavax			
• How many doses of COVID-19 vaccine have you received? _____			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of the COVID-19 vaccine	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
4. **Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised?**	☐	☐	☐
5. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	☐

6. Check all that apply to you:

☐ Have a history of myocarditis or pericarditis

☐ History of an immune-mediated syndrome such as heparin-induced thrombocytopenia (HIT)?

☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)

☐ Have a history of COVID-19 disease within the past 3 months?

☐ Have history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?

☐ History of Guillain-Barré Syndrome (GBS)

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet or patient fact sheet corresponding to the vaccine that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to me.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize Stauffer's Drug Store to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid, or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS: I understand that Stauffer's may be required to or may voluntarily disclose my health information to the physician responsible for this protocol, my Primary Care Physician, my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment, or other health care operations.

X _____ _____

Signature of patient or Guardian if age <18 **Date**