Grassroots Pharmacy

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Vaccine Administration Screening Form

Patient Name:	Allergies:
Address:	
City/State/Zip Code:	Sex (M/F):
Date of Birth:	Send copy to provider (Y/N)?
Phone #:	Provider name:
Emergency Contact Name/Phone #:	

Please answer the following questions to the best of your ability by circling your answer.

	1st	*2nd*	*UNSURE*
Is this your first or second dose of the COVID-19 vaccination?			
	YES	***NO***	***UNSURE***
1. Are you sick today?			
2. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the ingredients of this vaccine?			
3. Do you carry an Epi-pen for emergency treatment of anaphylaxis?			
4. For women, are you pregnant or is there a chance you could become pregnant?			
5. For women, are you breastfeeding?			
6. Have you had any other vaccinations in the previous 14 days?			
7. In the past two weeks, have you tested positive for COVID-19?			
8. Have you had in the last 10 days 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?			
9. Do you have allergies or reactions to any medications, foods, vaccines, or latex? Please explain:_____			
10. Are you immunocompromised or on a medicine that affects your immune system?			
11. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?			
12. 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 Grassroots Pharmacy or its agents 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 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 Grassroots Pharmacy, and their 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 vaccine listed above. • I acknowledge that: (a) I understand the purposes/benefits of KYIR, Kentucky's immunization registry and (b) Grassroots Pharmacy will include my personal immunization information in KY Immunization Registry and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies. • I further authorize Grassroots Pharmacy or its agents 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 Grassroots Pharmacy or its agents with respect to the above requested items and services. • I acknowledge receipt of the Notice of Privacy Rights.

Patient Signature: _____ Date: _____

Medicare PART B ID NUMBER:_____

Insurance ID:_____ Rx Group:_____ Rx BIN:_____ Rx PCN:_____

Below For Pharmacy Use Only

Vaccine	Exp Date	Lot #	Manufacturer	Injection Site	Route	Patient Info Given
				L Arm R Arm	IM	Y / N

Immunizer Signature: _____ License #: _____ Administration Date/Time: _____

Adverse Reactions? Y N (If yes, please explain on reverse side of sheet) Location: _____

PRIVATE AND CONFIDENTIAL: This communication and any attachments contain individual Protected Health Information. The disclosure of such information is governed by the Health Insurance Portability and Accountability Act. If you have recieved this communication from the sender in error, please notify the sender immediately and destroy the communication recieved.