LoRex Drugs

"Patient Care Sets Us Apart"

2020-21 COVID-19 VACCINE CONSENT FORM

All information below is needed to enter your vaccination into the SC Immunization Registry. Your doctor will also be notified via fax, as required by law.

Name (PLEASE PRINT)	**Date of Birth** (must be ≥ age 18)	**Sex** (circle) M F	
Address	**City, State, Zip**	**County**	**Telephone**
Physician Name	**Practice Name**	**Physician Phone**	**Physician Fax (if known)**

Ethnicity: *(check one)*
- ☐ Hispanic/ Latino
- ☐ Not Hispanic/ Latino
- ☐ Unknown

Race: *(check one)*
- ☐ American Indian
- ☐ Asian
- ☐ Black/ African American
- ☐ Native Hawaiian/ Pacific Islander
- ☐ White
- ☐ Unknown

Covid-19 Vaccine Information

The Janssen Covid-19 Vaccine includes the following ingredients: recombinant, replication-incompetent adenovirus type 26 expressing the SARS-CoV-2 spike protein, citric acid monohydrate, trisodium citrate dihydrate, ethanol, 2-hydroxypropyl-B-cyclodextrin (HBCD), polysorbate-80, sodium chloride.

Safety Questionnaire before Receiving covid-19 Vaccine	***Circle One***	
1. Are you sick today? *If you have fever, cough, diarrhea or vomiting, you should not get the vaccine until the illness has resolved.*	YES	NO
2. Have you ever received a dose of COVID-19 vaccine? • If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Other ____________	YES	NO
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with Epinephrine or had to go to the hospital.	YES	NO
• *Was the severe allergic reaction after receiving a COVID-19 vaccine?*	YES	NO
• *Was the severe allergic reaction after receiving another vaccine or injectable medication?*	YES	NO
• *Have you ever had an allergic reaction to Polysorbate?*	YES	NO
• *Have you ever had an allergic reaction to polyethylene glycol (PEG) which is found in some medications like laxatives and colonoscopy preps?*	YES	NO
4. Have you ever had a severe allergic reaction to something other than a component of the COVID-19 Vaccine, polysorbate, or any vaccine or injectable mediation? This would include food, pet, environmental, or oral medication allergies.	YES	NO
5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	YES	NO
6. Have you received another vaccine in the last 14 days?	YES	NO
7. Have you had a positive test for COVID-19 or has a doctor told you that you had COVID-19?	YES	NO
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?	YES	NO
9. Do you have a bleeding disorder or are you taking a blood thinner?	YES	NO
10. **For women:** Are you pregnant or considering becoming pregnant in the next month?	YES	NO

This pharmacy is providing necessary vaccines to you in a safe and convenient setting in order to promote adherence to current immunization guidelines recommended by the CDC and ACIP. It does not take the place of an ongoing relationship with your primary care provider to address ongoing medical issues and other types of preventive care. We are providing your primary care provider with records of the vaccine(s) administered here so that your medical records may be complete, but be sure to take your personal record with you to your next appointment as well. Please review the statement below confirming your consent for vaccination and provide the information requested.

I have read, or had explained to me, the CDC Vaccine Information Statement for Covid-19 vaccine . I understand the risks and benefits. I have been provided an opportunity to ask questions and they have been answered to my satisfaction. I wish to receive the Covid-19 vaccine and hereby give consent for a LoRex Drugs Pharmacist to administer the COVID-19 vaccine. I understand that LoRex Drugs will communicate the administration of the vaccine to my personal physician whose name and number I have provided. I release LoRex Drugs from all liability for any consequences which might result from this vaccine injection.

Signature ____________________   **Date** / /2021

NOTE: IT IS IMPORTANT TO VISIT YOUR PHYSICIAN REGULARLY TO RECEIVE OTHER PREVENTIVE MEDICAL SERVICES.

To be completed by Pharmacy	The above named patient received COVID-19 (Janssen) 0.5 ml IM					
	Lot:	042A21A	Expiration Date:	09/19/2021	Site:	R L Deltoid
	Signature of Administering Clinician:				Date:	/ / 2021
	☐ Candace C. Frick, PharmD	SC 9697	☐ Renee' Holstein, PharmD	SC 10324		
	☐ Heather C. Harris, PharmD	SC 11374	☐			