



"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 \geq age 18)	M	F	Sex (circle)
Address		City, State, Zip	County		Telephone
Physician Name		Practice Name	Physician Phone		Physician Fax (if known)
Ethnicity: (check one)	<input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Not Hispanic/ Latino <input type="checkbox"/> Unknown	Race: (check one)	<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black/ African American	<input type="checkbox"/> Native Hawaiian/ Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> 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- β -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 <u>not</u> 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? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> 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. • Was the severe allergic reaction after receiving a COVID-19 vaccine? • Was the severe allergic reaction after receiving another vaccine or injectable medication? • Have you ever had an allergic reaction to Polysorbate? • 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 medication? 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.

_____/_____/2021
 Signature Date

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:	1821288	Expiration Date:	10/30/21	Site:	R L Deltoid
	Signature of Administering Clinician:				Date:	/ / 2021
	<input type="checkbox"/>	Candace C. Frick, PharmD	SC 9697	<input type="checkbox"/>	Renee' Holstein, PharmD	SC 10324
<input type="checkbox"/>	Heather C. Harris, PharmD	SC 11374	<input type="checkbox"/>			