ECU Health Physicians: Pharmacy Immunization Patient Consent & Vaccine Administration Record Form

Last Name: _____ **First Name**: _____ **MI** ____ **Date of Birth**: _____ **Sex**: M / F

Address: _____ **City**: _____ **State**: ____ **Zip**: _____ **Phone**: _____ **County:**_____

Dose (Circle One): Bivalent Dose Immunocompromised Bivalent Dose 1 Immunocompromised Bivalent Dose 2 Aged 65+ Bivalent Dose

Email Address:_____ **Ethnicity (Circle One) Hispanic Non-Hispanic**

Race (Circle One): White American Indian or Alaska Native Asian Black or African American Other

Primary Insurance: _____ **ID#:** _____ **Group #:** _____

Please answer the following questions by placing an X in the answer box:	**YES**	**NO**	**DON'T KNOW**
1. Have you had a severe allergic reaction to a previous dose of mRNA COVID-19 vaccine or any components in the vaccine (including polyethylene glycol [PEG]?			
2. Have you had an immediate allergic reaction of any severity to polysorbate?			
3. Have you had a severe allergic reaction (e.g., anaphylaxis) after receiving another vaccine, medication, or ingesting food?			
4. Have you received another vaccine in the last 14 days other than the flu vaccine?			
5. Are you currently in quarantine for a known COVID-19 exposure or a positive COVID-19 test?			
6. Are you pregnant or breastfeeding?			
7. Have you received any Covid vaccinations previously?			
8. **For IMMUNOCOMPROMISED ADDITIONAL DOSE 1 ONLY**: Has it been at least 2 months since your initial Bivalent Covid vaccine dose?			
9. **For IMMUNOCOMPROMISED ADDITIONAL DOSE 2 ONLY**: Has it been at least 2 months since your last Bivalent Covid vaccine dose?			
10. **For PATIENTS AGED 65 OR OLDER DOSE ONLY**: Has it been at least 4 months since your last Bivalent Covid vaccine dose?			

Informed Consent, Waiver, and Notice of Privacy Practices: Please read the following statements and sign on the signature line below:

I hereby consent to engage in the vaccine service and authorize representatives of East Carolina University Brody School of Medicine Pharmacy Services to administer the vaccine(s) listed below. I am aware of the side effects of the vaccine(s) and request that it be given to me. ECU Health Physicians are not responsible for assuring that I have consulted with my physician with regard to my receipt of vaccine(s). I have received a copy of the Notice of Privacy Practices. In consideration of the vaccine(s) to be administered to me by ECU, I hereby assume all risks in connection with my participation and agree to hold East Carolina University, each of its officers, directors, agents and employees harmless from any and all injuries, claims, losses, damages, or liability arising out of or in any way connected with my participation in this service. I hereby waive for myself, my heirs, executors, and administrators all rights and claims for my participation in this program.

_____

Signature of patient to receive vaccine or person authorized to make the request (parent/guardian) Date

This section to be completed by Immunization Staff **ICD-10:Z23**

For Pfizer booster, verify patient is 12 or older:_____ (Staff Initial) Entered in EPIC:_____(MRN) Entered in CVMS:_____

Vaccine	Lot #	Exp. Date	Manufacturer	NDC	Dosage	Site (LA/RA)	Admin Schedule	VIS Date	CPT Code
Covid-19 Bivalent			Pfizer	59267-0304-1	0.3mL		Bivalent	Dec. 2020	0124A
Covid-19 Bivalent			Pfizer	59267-0304-1	0.3mL		IMM COMP 1	Dec. 2020	0173A
Covid-19 Bivalent			Pfizer	59267-0304-1	0.3mL		IMM COMP 2	Dec. 2020	0173A
Covid-19 Bivalent			Pfizer	59267-0304-1	0.3mL		Ages 65+	Dec. 2020	0174A

Immunizer Signature/Title/ Date / /