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:**________

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. Are you currently in quarantine for a known COVID-19 exposure or a positive COVID-19 test?			
4. Have you received any Covid vaccinations in the previous 2 months?			

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
Comirnaty Syringe			**Pfizer**	**00069-2392-1**	0.3mL		Monovalent		91320
Comirnaty Vial			**Pfizer**	**00069-2362-1**	0.3mL		Monovalent		91320

Immunizer Signature/Title/ Date / /