2000 W. Main Street
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Consent for Immunization with COVID-19 Vaccine

Last Name	First Name	Middle	Age	Date of Birth	Gender ❒M ❒F ❒Other
Home Address	**City**	**State**	**Zip**	**Phone # ❒Home ❒Cell** ( )	

Medicare Part B ID# or SSN: ____ **Driver's License #:** ____

Race: ❒Asian ❒Black or African American ❒Hispanic ❒American Indian ❒Caucasian ❒Pacific Islander ❒Other: ________________________________
Ethnicity: ❒Hispanic or Latino ❒Non-Hispanic or Latino ❒Decline to State (Unknown)

Screening Questionnaire: *Please answer questions:*

Screening Questions –REVIEW ANSWERS WITH PATIENT TO ENSURE NO CHANGES		Yes	No
1.	Are you sick today?	❒	❒
2.	Have you ever had an allergic reaction to COVID-19 vaccine or polyethylene glycol (PEG) or polysorbate?	❒	❒
3.	Have you ever had an allergic reaction to another vaccine (other than COVID-19) or to an injectable medication?	❒	❒
4.	Have you ever had a severe allergic reaction (anaphylaxis) to any food, pet, environmental allergens, oral medications, or latex?	❒	❒
5.	Have you received any vaccines in the past 14 days? (not a contraindication)	❒	❒
6.	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment in the last 90 days?	❒	❒
7.	Are you pregnant or breastfeeding? (not a contraindication)	❒	❒

From April 12,202
Must be >**18** yr. old for Mederna Vaccine.
Must be >**16** yr. old Pfizer Vaccine.

Informed Consent: Please read and sign.
By my signature below, I consent to the administration of the vaccine(s) by a provider or medical assistant, or other authorized person, where permitted by law or state/federal guidance, employed, or contracted by Physicians Express, LLC. I also release Physicians Express, LLC, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting, or arising from my receipt of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination and understand that I am obligated to pay for all products and services received, if applicable. 2) I may be responsible for payment after the date of service if the product or service is billed to my medical benefit. 3) I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient. 4) I will immediately alert staff of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine. 5) I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I am responsible for following up at Physicians Express, PCP or ER physician at my expense if I experience any side effects. 6) I should remain in the area for observation for 15 minutes unless I have a history of an immediate allergic reaction of any severity to a vaccine or injectable therapy or if I have a history of anaphylaxis due to any because I should remain in the area for observation for 30 minutes after the vaccination. If I leave the area without waiting, I acknowledge that I am doing so at my own risk and against the advice of the providers of Physicians Express, LLC. 7) I have read, the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization ("EUA") provided for the vaccine(s) to be administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). 8) I have been offered and/or provided a copy of the company's Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA). 9) This vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting by Physicians Express or its business associate to an immunization registry, which may share my immunization data with others, and to my primary care physician, the authorizing physician, or the local Department of Health, if applicable, and I authorize these disclosures.

X____ ____________________
Signature of Patient or Parent/Guardian of Minor Patient **Date**

Vaccine Name	Lot #	Expiration Date	Manufacturer	Dose (ml)	Dose #	Route	Site (circle)	VIS/EUA Publication Date
				0.5ml	1 / 2	IM	R / L Deltoid	12/01/2020

Name of Administrator: ____ Administration Date: _____________ Counseling (circle): Accepted / Declined