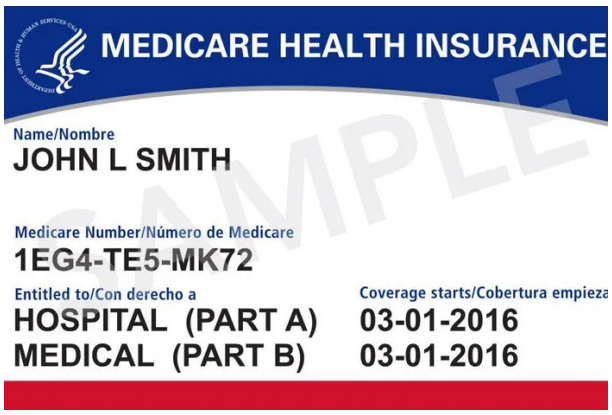
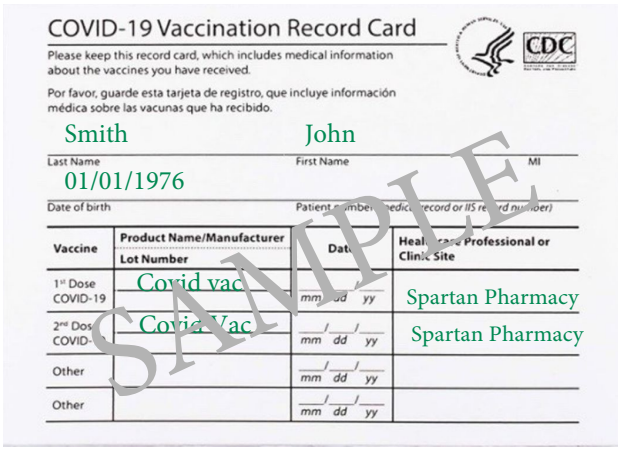
SPARTAN PHARMACY

1. Complete this form, print it out, sign it, and bring it and your COVID vaccine card with you when you come in for your appointment.
2. For faster service-make a copy of the following and bring to your appointment.
3. Attention Medicare patients: Your supplemental UPMC/ Highmark/ Aetna / United Healthcare cards are not what we need. We need your government issued Red White and Blue Medicare Card





3526 Brownsville Road
Phone: 412.884.4400
M-F: 9 am - 7 pm
Sat: 9 am - 4 pm
Sun: 10 am - 2 pm

3520 Saw Mill Run Blvd
Phone: 412.440.5888
Everyday: 8 am - 8 pm

3400 South Park Road
Phone: 412.831.1333
M-F: 9 am - 7 pm
Sat: 9 am - 4 pm
Sun: 10 am - 2 p

SPARTAN PHARMACY

Billed PA SIIS

COVID VACCINE CONSENT FORM

First Name _____ Last Name _____

Date of Birth _____ (Must be 18 or older)

Address _____

City/State/Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

Medicare A/B Number _____

Prescription Insurance Name _____

Insurance ID Number _____

Insurance Group _____

No Insurance: Please provide Social Security Number on back of this page.

Per the Pennsylvania Department of Health, we are required to ask the following questions.

1. Gender: Male / Female
2. Ethnicity: Hispanic or Latino / Non-Hispanic, Non-Latino / Unknown
3. Race: African American / Asian / Caucasian / Native American / Native Hawaiian or other Pacific Island

PATIENT CONSENT

1. I have had a chance to ask questions and they were answered to my satisfaction. I understand the risks and benefits and ask that the injection or vaccine be given to me or to the person for whom I am authorized to make this request.
2. I have received a copy of the Emergency Use Authorization (EUA) for the vaccine I will receive today:
3. FINANCIAL RESPONSIBILITY - By my signature below, I acknowledge that I have received the vaccine indicated above and authorize Spartan Pharmacy to bill and collect from my insurance for the vaccine and administration fees. If my insurancedenies payment for the entire or partial amount, I agree to be personally and fully responsible for payment.

Signature _____ Date _____

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Name _____

Age _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• Have you received a complete COVID-19 vaccine series *(i.e., 1 dose Janssen or 2 doses of an mRNA vaccine [Pfizer-BioNTech, Moderna])*?	☐	☐	
• Did you bring your vaccination record card or other documentation?	☐	☐	
3. Have you ever had an allergic reaction to: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including either of the following: ○ Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
4. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

5. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ History of Guillain-Barré Syndrome (GBS)

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists