COVID-19 Screening Questionnaire and Consent Form

Patient Name:_____Date of Birth:_____Age:_____Phone#_____
Address:_____City:_____State:_____Zip:_____
Gender: M or F Medical Conditions:_____Weight if less than 110 lbs:_____
Primary Care Physician:_____ Occupation:_____

Screening Questions	Yes	No	Unsure
Are you 18 years of age or older?			
Are you sick today?			
If yes to the above question: Do you have a new fever, cough, diarrhea, or vomiting?			
Have you ever fainted or felt dizzy after receiving a vaccine?			
Have you ever had a reaction after receiving a vaccine?			
Do you have a long-term health problem with heart or kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (diabetes) or anemia or another blood disorder?			
Do you have a long-term health problem with lung disease or asthma? Do you smoke?			
Do you have a history of myocarditis or pericarditis?			
Do you have a history of heparin-induced thrombocytopenia (HIT)?			
Do you have a weakened immune system b/c of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?			
Do you have allergies to medications, food (eggs), latex or any vaccine component (Polysorbate-80, 2-hydroxypropyl-B-cyclodextrin (HBCD), citric acid monohydrate, trisodium citrate dihydrate, sodium chloride, sodium hydroxide, hydrochloric acid, ethanol)?			
Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillan-Barre syndrome or other nervous system problems?			
Do you have dermal fillers?			
Have you ever received a dose of COVID-19 Vaccine? If yes, when and which one?_____			
Have you received any vaccinations in the past 14 days?			
Have you ever had an allergic reaction to another vaccine or injectable medication that required treatment with an EpiPen or required hospitalization?			
Have you ever tested positive for COVID-19? If yes, when_____			
Have you received monoclonal antibodies or convalescent plasma for treatment of COVID-19?			
For women: Are you pregnant or breast-feeding?			
If female, are you between ages 18 and 49?			
For men: If male, are you between the ages of 18 and 29?			

By signing below, you acknowledge the following: The Food and Drug Administration has approved the vaccine being administered to you on an emergency use basis as a vaccination for SARS-CoV-2 (Coronavirus or COVID-19), after having found it to be safe and effective in accordance with Emergency Use Authorization requirements. Information about the vaccine has been made available to you in the form of the Emergency Use Authorization (EUA) Fact Sheet. The vaccine being administered to you is not guaranteed to keep you from getting COVID-19. You may experience an adverse, even unexpected, reaction to it including, without limitation, all or some of the signs and symptoms listed on the EUA Fact Sheet. You are making an informed decision to receive the vaccine. You fully release and discharge Lake Murray Drug Company, its affiliates and assigns, and its officers, and employees from any illness, injury, loss, or damage that may result from the administration of the vaccine. You also agree to wait in the vaccination area for 15 to 30 minutes for monitoring and to receive treatment in case of adverse reactions. Your insurance company will be billed for the administration of the vaccine and any additional services provide in the event of an adverse reaction. Should you experience any symptoms, such as, without limitation, a fever of more than 101.5 F, fatigue, chills, headache, myalgia, or pain at the injection site, please contact your healthcare provider as soon as possible. If it is an emergency, please go to your nearest emergency medical provider if it can be done safely or contact 9-1-1.

I acknowledge that I have had an opportunity to read, understand and ask questions about the vaccine and the COVID-19 Vaccine Emergency Use Authorization (EUA) Fact Sheet relating to the vaccine I will be receiving and I accept all risks associated with such. I authorize Lake Murray Drug Company to release all information necessary to process my claims and provide the services above.

Patient Signature or legal guardian_____**Date**:_____

Pharmacy Use

Place Pharmacy Label Here

Covid-19: Janssen Pfizer Moderna Peds Pfizer

Date of Administration:_____ **Dose(mL):** _____

Site: Left/Right Deltoid **Lot**: _____ **Exp**: _____

Monitor Time: 15min/30min

Wendy Grooms (7228)
Justin Carter (12207)
Tyler Reynolds (36669)
Billy Mai (43080)
Vonda Fowke (8164)

Administered at: LMDC Chapin 803-345-9999

LMDC Irmo 803-212-9999

Signature_____