Pucci's PHARMACY
• SACRAMENTO'S PRESCRIPTION CENTER SINCE 1930 •

COVID-19 Vaccine Screening & Consent Form

First Name: _____ **Last Name:** _____ **DOB:** _____ (MM/DD/YYYY) **AGE:** ___ **GENDER:** _____

Race: ☐White ☐Black ☐Asian ☐Pacific Islander ☐Native American ☐Other **Ethnicity:** ☐Hispanic/Latino ☐ Not Hispanic/Latino

Phone: (____)_____ **Address:** _____ **City:** _____ **Zip:** _____

Rx BIN: _____ **Rx PCN:** _____ **Rx Group:** _____ **Member ID:** _____

Medicare Beneficiary ID Number (from Red, White and Blue Card) Applies to all individuals age 65+ even if you have an "Advantage Plan"	
Social Security Number (full number required – if you do not have SSN, please see a staff member):	
Mother's Maiden Last Name (Required for Immunization Record)	

Primary Care Physician: _____ **PCP Phone Number:** (____)_____

Please circle **YES** or **NO** for the following questions **and** answer **ALL** questions.

Are you feeling sick today?	**YES**	**NO**
Have you received a dose of COVID-19 vaccine? **If yes, which vaccine product did you receive?** ☐ **Pfizer** Date of administration: _____ Any side effects: _____ ☐ **Moderna** Date of administration: _____ Any side effects: _____	**YES**	**NO**
Are you allergic to polyethylene glycol (this is found in products such as cosmetics, skin care products, cough syrups, laxatives, bowel preps for colonoscopies, some food and drinks)	**YES**	**NO**
Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital? **If yes, explain:**	**YES**	**NO**
Do you have a severe bleeding disorder or are you taking a blood thinner?	**YES**	**NO**
Have you tested positive for COVID-19? **If yes, date of positive lab result:**	**YES**	**NO**
Have you received passive antibody therapy as a treatment for COVID-19? **If yes, when:**	**YES**	**NO**
Are you immunosuppressed?	**YES**	**NO**
Are you pregnant or planning to become pregnant?	**YES**	**NO**
Are you breastfeeding?	**YES**	**NO**
Have you ever felt faint or fainted after receiving a vaccine or medical procedure?	**YES**	**NO**
Have you received a vaccination within the last 14 days?	**YES**	**NO**

I have received, read, and understand the "Fact Sheet for Recipients and Caregivers" about the "Emergency Use Authorization (EUA) for the COVID-19 vaccine. I understand the benefits and risks of receiving this COVID-19 vaccine. I have had an opportunity to ask questions which were answered to my satisfaction. I hereby provide informed consent that the vaccine indicated below be given to me or to the person named above for whom I am authorized to make this request. Immunization given today will be enter into CAIR and share unless I object.

Parent/Guardian's Signature: _____ _____ Date: _____
Relationship to person above

For Official Use	Date	Vaccine / Mfg		Lot # & Exp. Date		Administered By	IM Site
		COVID-19 Vaccine	☐ Moderna. ☐ Janssen ☐ Pfizer				**LD RD**

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Self-Attestation Form for COVID-19 Vaccination:

Moderately to Severely Immunocompromised Patients

CDC recommends that people who are moderately to severely immunocompromised receive an additional dose of an mRNA COVID-19 Vaccine (Pfizer-BioNTech or Moderna) at least 28 days after the completion of the initial mRNA COVID-19 vaccine series.

Patients may self-attest to their condition by completing and signing this form.

Please check one of the following and sign at the bottom.

Moderately to severely immunocompromised includes people who have:

____ Receiving active cancer treatment for tumors or cancers of the blood

____ Received an organ transplant and are taking medicine to suppress the immune system

____ Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system

____ Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)

____ Advanced or untreated HIV infection

____ Active treatment with high-dose corticosteroids (i.e., ≥20mg prednisone or equivalent per day for ≥ 14 days) or other drugs that may suppress your immune response [e.g., alkylating agents (cyclophosphamide); antimetabolites (methotrexate); transplant-related immunosuppressive drugs (cyclosporine, tacrolimus, everolimus); TNF-blockers (etanercept)]

____ Other condition(s) which cause moderate or severe immunosuppression similar to the above conditions

People should talk to their healthcare provider about their medical condition, and whether getting an additional dose is appropriate for them.

Printed Full Name: _____ Date: _____

Signature: _____