COVID-19 Vaccine (Moderna) Screening & Consent

Last Name, First Name | Date of Birth | Age

Street Address | City | State | Zip Code

Primary Phone # | Email Address | List Drug Allergies

For patients who have not filled at Roden-Smith Pharmacy in the last 6 months please provide the option below that applies to you.

If you have Medicare Part B, list your ID# | If you have Tricare, list sponsors SS# | Other Insurance, list ID#, | Rx Bin, | Rx PCN, | Rx Group

☐ I do not have prescription insurance ☐ I do not know, but will provide my SS# so the pharmacy can do an eligibility check:

	YES	NO	NOT SURE
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
-If yes, which vaccine product and date? ☐ Pfizer, _____ ☐ Moderna, _____ ☐ Another Product, _____			
3. Have you ever had a severe reaction (e.g., anaphylaxis) to something?	☐	☐	☐
4. Have you received passive antibody therapy as treatment for COVID-19	☐	☐	☐
5. Have you received another vaccine in the last 14 days?	☐	☐	☐
6. Have you had a positive test for COVID-19?	☐	☐	☐
7. Do you have a weakened immune system caused by something such as HIV, cancer, or immunosuppressive drugs or therapies?	☐	☐	☐
8. Do you have a bleeding disorder or taking a blood thinner?	☐	☐	☐
9. Are you pregnant or breastfeeding?	☐	☐	☐

Vaccine Information & Selection

☐ Moderna Covid-19 (1st Dose)

☐ Moderna Covid-19 (2nd Dose) 28 Days after First

Immunization Consent

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of Roden-Smith Pharmacy, to administer the vaccine I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine. I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine I have elected to receive. I also acknowledge that during vaccination I will have a chance to ask questions pertaining to my vaccination. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Roden-Smith Pharmacy, its pharmacists, staff, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's immunization registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my immunization information to the State Registry, to the State HIE, or through the State HIE, to the State Registry, for purposes of public health reporting or to my health care providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I also authorize the applicable Provider to disclose my, or my child's (or unemancipated minor for whom I am authorized to act as guardian or in loco parents) proof of immunization to the school where I am, or my child (or unemancipated minor for whom I am authorized to act as guardian or in loco parents) is, a student or prospective student. I further authorize the applicable Provider to (a) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to, or through, the State HIE to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment, (b) submit a claim to my insurer for the above requested items and services, and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, the applicable Provider invoices me after the time of service, upon receipt of such invoice.

Signature **Date**

Pharmacy Use Only Section

Pharmacy Use

Prescribed By:

- ☐ **Micah Lansford, Pharm.D.,RPh (NPI 1831569151)**
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Clinic Number: **C5714** **RD** **LD**

NMSIIS By | Date | LOT # | Exp. Date | Site | Reviewed & Admin By | Date