Caldwell
Pharmacy~Home Medical Equipment~Gifts
(870) 238-7085 M-F 8:30-7; Sat. 8:30-2
www.caldwellmax.com

Pharmacist Immunization Program
Improving Arkansas wellness.

Name: _____

Date of Birth: _____ Age: _____ Gender (circle one): Male / Female

SSN: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Family Doctor: _____

Insurance Cardholder Name: _____ Cardholder Date of Birth: _____

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. Do you have a fever today?			
2. Are you feeling sick today?			
3. Do you have COVID-19 infection and are currently in isolation?			
4. Are you currently in quarantine for known exposure to COVID-19?			
5. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
6. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product and date received: □ Pfizer _____ □ Moderna _____ □ Another product _____			
7. Have you ever had a severe allergic reaction to something (Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital)?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent plasms) as treatment for COVID-19?			
9. Have you received another vaccine in the last 14 days?			
10. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
11. Do you have a bleeding disorder or are you taking blood thinner?			
12. Are you pregnant or breastfeeding or planning to become pregnant?			
13. Do you have allergies to latex?			
14. <18 years old: Have you had a well-child visit with your pediatrician in the last 12 months?			

Consent and waiver: I consent to the staff to administer the COVID-19 vaccine. I have reviewed the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. I fully release and discharge the standing order physician and the pharmacy, its affiliations and their officers, and employees from any illness, injury, loss, or damage that may result there from. I acknowledge that ***I have received a copy of the pharmacy's privacy policies according to HIPAA***. I understand that information about this COVID-19 vaccination will be included in (WebIZ) Arkansas Immunization Information System. I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to this COVID-19 Provider. I agree that the authorization will cover all medical services rendered until I revoke the authorization. I agree that the photocopy of this form may be used instead of the original. I am aware that an immunization certified student pharmacist might be administering this medication. **I agree to wait near the vaccination area for 15-30 minutes to receive treatment in case of adverse reaction.**

Signature of patient or guardian: _____