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: _____

Race: _____ Ethnicity (circle one): Hispanic or Latino/Non-Hispanic or Latino

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 told you that you had COVID-19?			
6. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product? □ Pfizer □ Moderna □ Janssen □ Other _____			
7. Have you ever had a severe allergic reaction to something (such as difficulty breathing, swelling of your face or throat, fast heartbeat, bad rash all over your body, dizziness and weakness) 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 to another vaccine or vaccine component (including polyethylene glycol in medications or laxatives and preparations for colonoscopy); to another injectable medication; or to polysorbate in vaccines, coated tablets or IV steroids or injectable therapy?			
• Was the severe allergic reaction to something other than listed above such as food, pet, venom, environmental or oral medications?			
8. Have you received monoclonal antibodies or convalescent plasms as treatment for COVID-19? Vaccine should be deferred for at least 90 days.			
9. Did you develop myocarditis or pericarditis after the first dose of COVID-19 vaccine? Do you have history of myocarditis or pericarditis prior to COVID-19 vaccination? Are you a male between age 12 through 29 years?			
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. Do you have dermal fillers? If swelling occurs at or near the filler injection site, usually face or lips, patient should contact their health care provider.			
13. Are you pregnant or breastfeeding or planning to become pregnant?			
14. Do you have allergies to latex?			
15. <18 years old: Have you had a well-child visit with your pediatrician in the last 12 months?			

NOTE: Recipients of Janssen COVID-19 vaccine should be instructed to seek immediate medical attention if they develop shortness of breath, chest pain, leg pain or swelling, persistent abdominal pain, neurological symptoms (including severe or persistent headaches or blurred vision), nausea, vomiting, petechiae or easy bleeding beyond the site of vaccination within 4 to 30 days of receipt of Janssen vaccine. Most people who have developed blood clots and low platelets were females age 18-49 years.

Consent and waiver: All of the information I have provided is correct. 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 this 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: _____