COVID-19 VACCINE ADMINISTRATION FORM

SECTION 1 – INFORMATION ABOUT THE PERSON RECEIVING THE VACCINE

Name: _____ Date of Birth: _____ / _____ / _____ Age: _____

Phone: (_____)_____ ☐ This is a mobile phone ☐ I wish to receive text message alerts regarding my vaccine(s) -OR-

Email address: _____ ☐ I wish to receive email alerts regarding my vaccine(s)

Address: _____ City: _____

County: _____ State: _____ Zip Code: _____

Have you ever received a COVID-19 vaccine? ☐ Yes ☐ No If yes, manufacturer name: _____ Date received: _____

Race: American Indian or Alaska Native Asian Black or African American
Native Hawaiian or Other Pacific Islander White Other [Prefer not to disclose

Gender: ☐ Male ☐ Female ☐ Other

Ethnicity: Hispanic Non-Hispanic Prefer not to disclose

H-E-B Pharmacy will contact your primary care provider informing them of vaccine(s) given today using the information provided below

Primary Care Provider Name: _____ Phone: (_____)_____ Fax: (_____)_____

SECTION 2A – QUESTIONS TO DETERMINE VACCINE ELIGIBILITY (circle YES or NO)

1. Do you currently have COVID-19 or have you had it in the last 90 days?	YES NO
2. Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies or convalescent plasma)?	YES NO
3. Are you sick today or do you have any of these symptoms: fever, chills, shortness of breath, body aches, loss of taste/smell	YES NO
4. Have you ever had an anaphylactic reaction, serious allergic reaction, or any other serious reaction to a vaccine?	YES NO
5. Have you had any vaccinations in the past 14 days?	YES NO

SECTION 2B – CLINICAL CONSIDERATIONS (circle YES or NO)

6. Are you pregnant or breastfeeding?	YES NO
7. Are you immunocompromised or taking medications that affect your immune system?	YES NO
8. Are you taking blood-thinning medications or do you have a bleeding disorder?	YES NO

SECTION 3 – PLEASE READ CAREFULLY AND ACKNOWLEDGE WHERE APPROPRIATE

I hereby give my consent to the H-E-B Pharmacy ("H-E-B") to administer the vaccine(s) (the "Services") I have requested below. Section Date: Dec 2020

With my initials, I certify that:

_____ I am: (i) the Patient and at least 18 years of age; (ii) the parent or guardian of the minor Patient; or (iii) the legal guardian of the Patient; or (iv) a person authorized under the law of another state or a court order to consent for the child; OR

_____ The persons identified under (ii), (iii), or (iv), in the preceding sentence are unavailable and I have authority to consent to the immunization of the child because I am a (i) grandparent; (ii) adult brother or sister; (iii) adult aunt or uncle; (iv) stepparent; or (v) another adult who has actual care, control, and possession of the child and has written authorization to consent for the child from a parent, managing conservator, guardian, or other person who, under the law of another state or a court order, may consent for the child; additionally, I certify that I do not have knowledge of any express refusals or withdrawn authorizations of consent and have not been told not to give consent for the child.

I understand that any Protected Health Information ("PHI") I provide H-E-B will only be used or disclosed by H-E-B in accordance with H-E-B's Health Insurance Portability and Accountability Act ("HIPAA") Notice of Privacy Practices. By signing below I acknowledge receipt of such HIPAA Notices of Privacy Practices and consent to the uses and disclosures of PHI described therein. While H-E-B reserves the right to not do so, I consent to H-E-B reporting my immunization information to the State Immunization Registry. Should H-E-B elect to report my immunization history to the Texas central immunization registry, ImmTrac, I further understand that my immunization information may be accessed by other health care providers, educators, public health representatives, state agencies and certain insurance payers. I further authorize H-E-B to (1) release my medical or other information to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment or otherwise, (2) submit a claim to my insurer for the below requested items and services, and (3) request payment of authorized benefits be made on my behalf to H-E-B with respect to the below requested items and services.

NOT A SUBSTITUTE FOR A PHYSICIAN

I understand that H-E-B Pharmacy representatives are not physicians trained to diagnose and treat medical problems. I acknowledge that the administration of Services does not constitute, and should not be interpreted as, medical advice or opinions substituting for the advice of a physician. I understand that the administration of Services does not create a doctor-patient relationship between myself and H-E-B. I agree to consult a physician if I require medical advice or services at any time.

RELEASE, IMDEMNITY AND DISCLAIMER

I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s), including novel COVID-19 vaccine(s). I understand the risks and benefits associated with novel vaccine(s) and elect to receive a COVID-19 vaccine. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I additionally acknowledge that I have received a copy of the H-E-B Pharmacy notice of privacy. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering health care provider. I understand that in the course of the requested vaccine administration, an H-E-B Pharmacy representative could possibly be exposed to my blood or bodily fluids. In such event, I agree to review and execute the "H-E-B Post-exposure Consent for Testing" form.

On behalf of myself, my heirs and personal representatives, I further hereby WAIVE, RELEASE, and AGREE TO INDEMNIFY, DEFEND AND HOLD HARMLESS (including for costs and attorney's fees) H-E-B, its staff, agents, employees and corporate affiliates 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 COVID-19 vaccine(s) and related services, even should such damages or losses result from H-E-B's negligence.

I have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet or the Vaccination Information Statement for the vaccine I have elected to receive.

Patient Signature: _____ **Date:** _____
(Parent or Legal Guardian, if minor)

SECTION 4 – INSURANCE INFORMATION

Please record both pharmacy and medical insurance information:

	PHARMACY CARD	MEDICAL CARD
Plan/Carrier Name		
Member ID #		
Group #		
RX BIN		Not applicable
RX PCN		Not applicable

Policy Holder Name (if different):

_____

Policy Holder Date of Birth: _____

FOR MEDICARE PART B:

	MEDICARE PART B
Medicare Number*	
Last 4 digits of SSN**	

*number on red, white, & blue Medicare card

**for insurance verification, if needed

MEDICARE STATEMENT: I request that payment of authorized Medicare benefits be made either to me or on my behalf to HEB Pharmacy for any service furnished to me by HEB Pharmacy. I authorize release to the Centers for Medicare and Medicaid Services and its agents any medical information about me needed to determine the payments for related services.

Name of Beneficiary: _____

Signature: _____ **Date**: _____

IF UNINSURED:

I attest that I do not have any medical or pharmacy insurance. ☐Yes

Social Security Number: _____-_____-_____ (this is needed by the federal government if you do not have health insurance)

SECTION 5 – PHARMACY USE ONLY

Temperature checked by (Partner initials): _____

Vaccine	Amount Administered	Manufacturer	Dose # (circle)	Route	Lot Number / Expiration Date	Site of Administration*	Reviewed Vaccine Complete (initial)
COVID-19 vaccine	0.3 ml	Pfizer	1 or 2	IM		RD LD	Initial here
COVID-19 vaccine	0.5 ml	Moderna	1 or 2	IM		RD LD	Initial here
COVID-19 vaccine	0.5 ml	Janssen	1 only	IM		RD LD	Initial here
COVID-19 vaccine						RD LD	Initial here

* RD - Right Deltoid, LD - Left Deltoid, RA - Right Arm, LA - Left Arm

Vaccine Information

Pfizer – 2 shot series at 0 and 21 days, authorized for 16 years of age and older
Moderna – 2 shot series at 0 and 28 days, authorized for 18 years of age and older
Janssen (Johnson & Johnson) – single shot (1 dose), authorized for 18 years of age and older

H-E-B Pharmacy Location	To Be Completed by Pharmacist	Technician Immunizer (if applicable)
Corp #:	Pharmacist Initials: _____	Immunizer Initials: _____
Address:	TX License #: _____	TX Registration #: _____
City, State:	Signature: _____	Signature: _____
	Clinic Location: _____	
	Date of Immunization: _____ **Next Dose Due Date:** _____	