Discount Drug Mart COVID Clinic Vaccine Administration and Consent Form
Crawford and Richland County Students

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT) ALL SECTIONS MUST BE COMPLETED				
FIRST NAME:	**LAST NAME:**			**HOME ADDRESS COUNTY:**
ADDRESS:	**CITY:**		**STATE:**	**ZIP CODE:**
DATE OF BIRTH:	**AGE:**	**GENDER:**	**PHONE NUMBER:**	
ALLERGIES:	**CHRONIC ILLNESS:**			
PRIMARY CARE PHYSICIAN:	**ADDRESS:**		**PHYSICIAN PHONE NUMBER:**	
PARENT/GUARDIAN FIRST NAME:	**PARENT/GUARDIAN LAST NAME:**		**PARENT/GUARDIAN PHONE NUMBER:**	

RACE (CIRCLE ONE):	**ETHNICITY:**
White **Black/African American** **Hispanic** **Asian** **American Indian/Alaskan Native** **Prefer Not to Answer** **Native Hawaiian/Other Pacific Islander** **Other**	**Are you of Hispanic, Latino, or Spanish origin? (SELECT ONE):** □ **Yes-Please specify:**_____ □ **No-Not Hispanic, Latino, or Spanish origin**

BILLING INFORMATION				
CIRCLE ONE: **MEDICARE B** **MEDICARE D** **PRESCRIPTION PLAN** **MAJOR MEDICAL** **CASH**				
PLAN NAME:		**ID NUMBER:**		
GROUP:		**RELATIONSHIP:**		
RX BIN:	**RX PCN:**		**RX GROUP:**	

SCREENING QUESTIONNAIRE FOR IMMUNIZATIONS	**YES**	**NO**
1. Are you sick today or experiencing any symptoms which may be associated with COVID-19?		
2. Do you have any allergies to medication, food, latex, polyethylene glycol (PEG), or any vaccine component or have you ever had a serious reaction after receiving a vaccine? Please list:		
3. During the past year, have you received a transfusion of blood or plasma or been given immune globulin?		
4. Are you pregnant, planning on becoming pregnant in the next month, or breast feeding?		
5. Have you had any vaccines administered to you in the past 14 days?		
6. Do you have a history of a bleeding disorder or are you taking blood thinners?		
7. Have you ever received a COVID vaccine? If Yes, which manufacturer (please circle one)? **Pfizer** **Moderna**		
8. Have you ever had a positive test for COVID-19 or been told that you have had COVID-19? If Yes, please list approximate date:		
9. Have you received antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? If Yes, please list approximate date:		
10. Select the most appropriate Target Population/Occupation code on the back of the form.		
11. Do you have a temperature? *Note: Temperature will be taken prior to vaccine administration.*		

SIGNATURE AUTHORIZING VACCINATION: _____DATE: _____

[Person to receive vaccine or person authorized to make request (parent or legal guardian)]For **MEDICARE** or INSURANCE recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to Discount Drug Mart. If a claim rejects, I will be charged cash. For patient reimbursement, the patient must submit their Cash Receipt to their major medical benefits provider.

Physician on Record: Julia Bruner, MD MS 2500 MetroHealth Drive Cleveland, OH 44109

I have read or have had explained to me the information in the EUA about the vaccine I circled above. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. I agree to receive treatment for any adverse event that may occur

OVER →

after receiving the vaccine while on site. In the event of an accidental post vaccination needle stick to the vaccine administrator, I agree to be contacted for follow up lab work. I have received the EUA Form and the Discount Drug Mart NOPP.

PLEASE CHECK ANY & ALL TARGET POPULATION/OCCUPATION CODES THAT APPLY:

	TPV1	Assisted Living Facility – Resident		TPV24	Individual with congenital disorder or early onset conditions (see TPV22 for list of conditions) **WITHOUT IDD** (intellectual or developmental disabilities)
	TPV2	Assisted Living Facility – Staff		TPV25	Diabetes Type 1
	TPV3	Skilled Nursing Facility (RCF) – Resident		TPV26	Pregnant
	TPV4	Skilled Nursing Facility (RCF) – Staff		TPV27	Bone Marrow Transplant Recipient
	TPV5	State of Ohio DoDD Resident		TPV28	ALS
	TPV6	State of Ohio DoDD Staff		TPV29	Childcare Services Worker
	TPV7	State of Ohio Veterans Home Resident		TPV30	Funeral Services Worker
	TPV8	State of Ohio Veterans Home Staff		TPV31	Law Enforcement, Corrections, Firefighter
	TPV9	State of Ohio MHAS Resident		TPV32	Diabetes Type 2
	TPV10	State of Ohio MHAS Staff		TPV33	End Stage Renal Disease
	TPV11	State of Ohio DRC LTC residents		TPV34	Cancer
	TPV12	State of Ohio DRC LTC staff		TPV35	Chronic Kidney Disease
	TPV13	Congregate Care Facility – Resident		TPV36	Chronic Obstructive Pulmonary Disease
	TPV14	Congregate Care Facility - Staff		TPV37	Heart Disease
	TPV15	Hospital worker – Clinical Staff		TPV38	Obesity
	TPV16	Hospital worker – Administrative Staff		TPV40	Individuals age 40 to 49 years of age
	TPV17	Hospital worker– Ancillary Staff		TPV50	Individual age 50 to 59 years of age
	TPV18	Non-Hospital healthcare worker – Administrative Staff		TPV60	Individual of 60 to 64 years of age
	TPV19	Non-Hospital healthcare worker– Ancillary Staff		TPV65	Individual over 65 years of age
	TPV20	Non-Hospital healthcare worker – Clinical Staff		TPV70	Individual over 70 years of age
	TPV21	Emergency Medical Services (EMTs/Paramedics)		TPV75	Individual over 75 years of age
	TPV22	Individual with congenital disorder or early onset conditions (cerebral palsy; spina bifida; congenital heart disease; type 1 diabetes; inherited metabolic disorders; severe neurological disorders, including epilepsy; severe genetic disorders, including Down syndrome, fragile X syndrome, Prader-Willi syndrome, and Turner syndrome; severe lung disease, including cystic fibrosis and severe asthma; sickle cell anemia; and alpha and beta thalassemia) **WITH IDD** (intellectual or developmental disabilities)		TPV80	Individual over 80 years of age
	TPV23	Individual working in K-12 schools		TPVALL	Individuals age 16 to 39 years of age

Circle Dose, Manufacturer, and Admin Site

Dose: First Dose Second Dose **Manufacturer:** Pfizer/0.3ml

Administration Site: R Arm L Arm **Lot:** **Exp Date:**

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Signature and Title of Vaccine Administrator:_____

Printed Name:_____ Date:_____

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