SAVAGES DRUG

HEALTH SCREEN & CONSENT FORM – COVID-19 Vaccine

Please answer the following questions about the person to be vaccinated.

Name:	Date of Birth:	Age:
Prescription Insurance *Please fill out the information below or provide a copy of your insurance card* ID#: _____ RX BIN:_____ RX PCN:_____ RX Group:_____ Medicare A&B (if applicable): _____	Gender: ☐ Male ☐ Female ☐Non-Binary/X ☐Transgender ☐Prefer not to disclose ☐Other _____	
Race: ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐Black or African American ☐White ☐Other Race	Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Non-Latino	
Street Address:	City/Zip:	Phone:

Please answer the following questions about the person named above.	**Yes**	**No**
1. Have you ever received a dose of COVID-19 vaccine? *If yes, documentation is required.*	☐	☐
2. Are you feeling sick today?	☐	☐
3. Have you been advised to isolate or quarantine at this time?	☐	☐
4. Are you moderately to severely immune compromised?	☐	☐
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis)? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital.	☐	☐
6. Have you ever had an allergic reaction to a previous COVID-19 vaccine? For example, did you have hives, swelling, or wheezing within 4 hours of vaccination?	☐	☐
7. Do you have a history of myocarditis or pericarditis?	☐	☐
8. Have you received passive antibody therapy in the last 90 days?	☐	☐

FOR VACCINE RECIPIENTS <18 YEARS OF AGE, GUARDIANS PLEASE CHECK ONE OF THE FOLLOWING BOXES:

☐ My child's immunizations **can be done without** my presence.

☐ My child's immunizations **can only be done with** my presence.

PERMISSION TO VACCINATE

- I was given a copy of the Emergency Use Authorization Fact Sheet, which I have read or had this fact sheet explained to me, and I understand the benefits and risks of the COVID-19 vaccine.
- I understand that a record of this vaccination will be entered into the Maine Immunization Information System, ImmPact.
- I understand that I am advised to stay on site today for at least 15 minutes post-vaccination.
- **I give permission for the COVID-19 vaccine to be given to the person named above by signing below.**

X_____Date:_____

Signature of guardian of person to be vaccinated or Signature of adult to be vaccinated

FOR OFFICE USE ONLY:

Dose	**Date Dose Administered**	**Vaccine Manufacturer**	**Lot Number**	**Dose Volume**	**Vaccine Provider**	**Injection Site Deltoid**	**Route**	**EUA date**
Dose 1 ___/___/___ Dose 2 ___/___/___ Dose 3 ___/___/___	/ /	Pfizer (12+) Pfizer (5-11) Moderna (18+) Janssen (18+)				Left Right	☐IM	

December 15th, 2021