Lela Pharmacy COVID-19 VACCINE SCREENING

SECTION 1: INFORMATION ABOUT YOU or PERSON RECEIVING

Please Print

Last Name	First Name	Middle Initial	**SSN OR IF NONE N/A**
			Driver's License **(TRICARE)**

Date of Birth			Age in Years	Sex: □ Male □ Female
Month	Day	Year		Email Address:

Race	Ethnicity
□American Indian or Alaska Native □Native Hawaiian or Other □Other Asian □Other □Asian □Pacific Islander □Other Nonwhite □Black or African American □White □Other Pacific Islander	□Hispanic or Latino □Not Hispanic or Latino □Unknown

Address		
City	State	Zip Code

Cell Phone Number	Do you have health insurance? **YES** ☐ **NO** ☐	Insurance Name/Medicare (Part A/B number) **Include SSN at the top if you don't have the card.**
		Insurance Name / **Member #**

Dose type: 1st, 2nd, 3rd or Booster COVID-19 vaccination? □ First Dose □ Second Dose □ Third □ Booster Dose

SECTION 2: COVID-19 SCREENING QUESTIONS

Please check YES or NO for each question.	**YES**	**NO**
1. Are you sick today?		
2. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
3. Do you carry an Epi-pen for emergency treatment of anaphylaxis?		
4. For women, are you pregnant or is there a chance you could become pregnant?		
5. For women, are you breastfeeding?		
6. In the past 90 days, have you received monoclonal antibodies?		
7. Have you had, in the last 10 days, fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?		

SECTION 3: If you have received a previous COVID-19 vaccine dose (SKIP SECTION 3 IF THIS IS YOUR FIRST DOSE)

Please check YES or NO for each question.	**YES**	**NO**
8. List health problems?		
9. Do you have allergies or reactions to any medications, foods, vaccines, or latex? Please explain:		
10. Are you immunocompromised or on a medicine that affects your immune system?		
11. Are you at increased risk for COVID-19 due to your occupational or institutional setting?		
12. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
13. Indicate which manufacturer's vaccine you received and date the dose was administered: □ Janssen (J&J) □ Moderna COVID-19 vaccine □ Pfizer-BioNTech COVID-19 vaccine		
14. Did you experience a non-severe allergic reaction within 4 hours of a previous dose of COVID-19 vaccine? Non-severe allergic reactions can include: hives, swelling, redness, wheezing, GI symptoms, etc)? If yes, please explain:		

Continued on back (or 2nd page)

- I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the patient and confirm that the patient is at least 5 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Texas Department of State Health Services (TxDSHS) or Lela Pharmacy or their agents to administer the COVID-19 vaccine.
- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 5 years of age and older for the Pfizer-BioNTech COVID-19 vaccine and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I also understand the need for continued masking/social distancing after receiving the COVID-19 vaccination
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation and possibly up to 30 minutes if the medical provider deems necessary. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- I acknowledge that: (a) I understand the purposes/benefits of ImmTrac2, Texas immunization registry and (b) TxDSHS will include my personal immunization information in ImmTrac2 registry, and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I acknowledge receipt of the Notice of Privacy Rights.
- I voluntarily elect to receive the COVID-19 vaccination being administered by Lela Pharmacy or their designated agent after carefully considering the risks and benefits.
- Lela Pharmacy advised me to consult with my medical provider to discuss my personal risks, benefits, and potential side effects of receiving the COVID-19 vaccination.
- I understand that the COVID-19 vaccinations given at Lela Pharmacy will be tracked and reported to ImmTrac2, and as otherwise required by the local, state and federal government.

Signature of Patient or Authorized Representative: _____ **Date:** _____

Signature

Print Name of Representative and Relationship to Person Receiving Vaccine: _____

Staff Use

Site (LD/RD)	Route	Manufacturer	Lot Number	Expiration Date	Date of EUA Fact Sheet
LD/RD LVLt/LVRt	IM	Pfizer-BioNTech/J&J/Moderna			

Administered by:	Lela Pharmacy
Location Address:	2561 Jackson Keller, , San Antonio, TX 78230
Clinic Phone Number:	(210) 348-1532

Vaccinator (Print Name):		Signature:		Date:	
Co-Signature with Credentials, if indicated					