GOOD NEIGHBOR PHARMACY
Newhard Pharmacy
& Long Term Care
Phone: 610-262-6721
Fax: 610-262-7593
Mon-Fri: 9am - 7pm, Sat: 9am - 3pm, Sun:Closed
www.newhardpharmacy.com

COVID-19 Immunization Booster Consent Form

Section 1: Information about Patient to Receive COVID-19 Vaccine *(please print)* *ALL FIELDS REQUIRED

PATIENT'S NAME (Last)	(First)	**DATE OF BIRTH** month_____ day_____ year _____	
SOCIAL SECURITY # (if Medicare age or No Insurance)		**AGE**	**GENDER** M / F
ADDRESS & CITY		**STATE**	**ZIP**
ETHNICITY (please circle) Asian Black/African American Hispanic/Latino White Other	**CELL PHONE**	**EMAIL**	

Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if you are eligible to receive the COVID-19 vaccine today.
Please check YES or NO for each question.

	BOOSTER YES	BOOSTER NO
1. Are you feeling sick today?	☐	☐
2. Have you ever received a dose of any COVID-19 vaccine? If so, which product? Pfizer Moderna J&J_____	☐	☐
3. Do you have any allergies to medications, food, latex, or vaccine component?	☐	☐
4. Have you ever had a severe allergic reaction (i.e anaphylaxis)? For example, a reaction for which you were treated with an EpiPen (epinephrine) or for which you had to go to a hospital? Was the severe allergic reaction from -- A previous COVID-19 vaccine? Another vaccine, injectable medication, or shellfish?	☐ ☐ ☐	☐ ☐ ☐
5. Do you meet the CDC Guidelines for over age 65 or high risk individuals?	☐	☐
6. Have you received another vaccine in the last 28 days?	☐	☐
7. Do you have a bleeding disorder or are you taking blood thinners?	☐	☐

Patient or Adult Signature _____ Date: _____/_____/_____

Screening Questions reviewed by: _____

Flip to Back Side>>>>>>

Section 3: Patient Consent

I have read or had explained to me the current Vaccine Information Statement (EUA) for the COVID-19 vaccine and understand the risks and benefits.
Pfizer-BioNTech COVID-19 Vaccine Overview and Safety | CDC

I have read or had explained to me the current Vaccine Information Statement (EUA) for the COVID-19 vaccine and understand the risks and benefits.
https://www.modernatx.com/covid19vaccine-eua/

- **I DO GIVE CONSENT** -- By signing below, I give consent to Newhard Pharmacy and it's staff, to vaccinate myself with the COVID-19 vaccine additional dose and to report any data collected on this form to the required State and/or Federal agencies as required (if this consent form is not signed, then the patient will not be vaccinated).

I also agree to hold harmless Newhard Pharmacy, its directors, officers, employees, agents, and stockholders from and against all claims, demands, actions, suits, damages, liabilities, losses, settlements, judgments, costs and expenses (including but not limited to reasonable attorney fees and costs), whether or not involving a third-party claim, which may arise out of, or relate to, the administration of this vaccine.

Patient or Adult Signature (BOOSTER) _____ Date: _____/_____/_____

Section 4: Insurance Information

Please fill out if not providing insurance card.

Prescription Insurance Information

Insurer:_____
ID:_____
RX Group:_____
RX BIN:_____
RX PCN:_____

Medical Insurance Information

Insurer:_____
ID:_____
Group:_____

Medicare ID*:_____
*Requires Red, White, and Blue Card

Pharmacy Use Only

Section 5: Vaccination Record

Vaccine	Booster Dose	Route (I.M.) Deltoid	Date Dose Administered	Vaccine Manufacturer Lot/ Exp	Pharmacist Initials
COVID-19 BOOSTER	3	☐ Left ☐ Right	/ /		

Pharmacist:

- John J. Pavis, RPh, NPI: 1184879884
- Charlie Wolfangle, RPh, NPI: 1700473618
- Alison Undercoffler, RPh, NPI: 1811584089
- Dawn Weber, RPh, NPI: 1487750337
- Tony Kapinas, RPh, NPI: 1962099093
- Kyle Zehner, RPh, NPI: 1740877265
- Nancy Arbogast, RPh, NPI: 1982228516
- Dominique Gross, RPh, NPI: 1700124476

Additional Dose

- Entered into QS1/PA-SIIS