SECTION 1: PATIENT INFORMATION

This section must be completed for residents/facility staff receiving the vaccine.

First Name:	Last Name:
Date of Birth:	Gender: ☐ Male ☐ Female
Allergies:	☐ No Known Drug Allergies
Facility Name & Address:	

Race/Ethnicity: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino American ☐ Pacific Islander ☐ White ☐ Other, specify:

Mother's First Name: ☐ Unavailable	Mother's Maiden Name: ☐ Unavailable

Patient Guardian Type (Please select from the options below):

☐ Aunt (AUN)	☐ Child (CHD)	☐ Guardian (GRD)	☐ Parent (PAR)	☐ Sister (SIS)	☐ Uncle (UNC)
☐ Brother (BRO)	☐ Foster Child (FCHI)	☐ Grandparent (GRP)	☐ Self (SEL)	☐ Spouse (SPO)	☐ Other (OTH):
☐ Caregiver (CGV)	☐ Father (FTH)	☐ Mother (MTH)	☐ Sibling (SIB)	☐ Stepchild (SCH)	☐ Unavailable

I consent to receive the following vaccination(s) [Vaccine]: SARS-CoV-2 Vaccine (2-dose series) ☐ **Yes** ☐ **No**

SECTION 2: HEALTHCARE WORKER INFORMATION

Facility Staff receiving the vaccine must complete section 2 below.

Medical Conditions:			
Mailing Address:			
Street:	City:	State:	Zip:
Personal Phone Number:	Personal Email Address:		
Primary Care Provider (PCP):	PCP Phone Number:		

Insurance Information (Please fill table below or check "No Insurance" if not insured)

☐ **No Insurance**	**Pharmacy/Medication**	**Medical**
Insurance Plan/Plan ID		
Member/Recipient ID Number		
RX BIN		N/A
RX PCN		N/A
Group Number		

Are you the cardholder? ☐ Yes ☐ No If no, please provide the Cardholder's name, date of birth and relationship below:

Cardholder Name:	Cardholder DoB:	Relationship to Cardholder:

SECTION 3: CONSENT

Please read the following statements and sign below on the signature line.

I have received, read and understand the COVID-19 Vaccine Information provided by PharmScript. I hereby authorize PharmScript and the practitioners employed by or contracted with PharmScript (each, a "Provider") to administer the Vaccine I have requested above as a two-dose regimen series administered 19 to 23 days apart (the "Services"). The scope of this consent includes discussion about the vaccine(s) and its administration between PharmScript and other health care professionals for purposes of care and treatment. I understand that I may withdraw this consent at any time by making a request in writing.

Continued on next page.

SECTION 3: CONSENT

Please read the following statements and sign below on the signature line.

I acknowledge that I have been informed about, the following:

- The goal of the Services is to administer the Vaccine I requested.
- The Provider(s) will provide me with additional information about any risks associated with the Services, which depend upon my specific diagnoses and health status.
- Administering Vaccines is not an exact science and there are no guarantees as to the results of the Services that may be provided to me.
- The nature and purpose of the Services, expected benefits, potential known and unknown complications, likelihood of achieving goals, and relative risks that may arise from the Services, along with the relevant risks and consequences of no treatment.

I understand the benefits and risks of the Vaccine and I expressly consent, request, and authorize the administration of the Vaccine. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless PharmScript, each Provider and the applicable staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liability or claims, whether known or unknown, arising out of, in connection with, or in any way related to the Services.

I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registration ("State Registry") and my state's health information exchange ("State HIE"); and (b) the Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination.

I further authorize the applicable Provider to: (a) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to, or through, the State HIE to my healthcare professionals, Medicare, Medicaid, or other third-party payers as necessary to effectuate care or payment; (b) submit a claim to my insurer for the Services; and (c) request payment or authorized benefits be made on my behalf to the applicable Provider with respect to the Services.

I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the Provider: (a) the disclosure of my vaccination information by the Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The Provider will, if my state permits, provide me with an Opt-Out Form. I understand that I may need to consent, depending on my state's law, and to the extent so required, I hereby do consent by signing below to the Provider reporting my vaccination information to the State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent Form. Unless I provide the Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the Provider and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my vaccination information to or through the State HIE as required or permitted by law.

Photocopies/electronic transmissions/faxes of this consent and any signatures are to be considered as valid originals.

MY SIGNATURE BELOW INDICATES THAT I VOLUNTARILY AGREE TO ALL OF THE ABOVE AND THAT THE NATURE OF THIS CONSENT WAS EXPLAINED TO ME AND THAT I HAD THE OPPORTUNITY TO ASK ANY AND ALL QUESTIONS REGARDING THE ABOVE AND MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I UNDERSTAND THE BENEFITS AND RISKS OF THE VACCINE AND I EXPRESSLY CONSENT, REQUEST AND AUTHORIZE THE ADMINISTRATION OF THE VACCINE. I HAVE BEEN PROVIDED WITH THE CDC'S VACCINE INFORMATION SHEET(S) OR THE EMERGENCY USE AUTHORIZATION (EUA) PATIENT FACT SHEET CORRESPONDING TO THE VACCINE THAT I AM RECEIVING.

If signing on behalf of the patient, please provide the following information:

☐ I am the legal and authorized representative of the patient and am authorized to sign this consent on the patient's behalf.

☐ The patient verbally agreed to all of the above and provided verbal consent but is unable to physically sign this consent form. Patient has verbally provided me with authorization to sign this consent on patient's behalf.

☐ The legal and authorized representative of the patient verbally agreed to all of the above on behalf of patient and provided verbal consent on behalf of the patient and verbal authorization for this consent to be signed.

Print Name (Signatory):	Signature:	Date:

Guardian Name:

Relationship to Patient (if applicable): ☐ Spouse ☐ Power of Attorney ☐ Legal Guardian ☐ Other, Please Specify:
(If "Other", refer to witness section)

Witness (use for Relationship To Patient is "Other"): (optional)

Signature:	Print Name: