Date: _____ Time: _____ HD:____ Quad:____ P:____ M:____ J:____

GUIDEPOINT PHARMACY COVID-19 / INFLUENZA VACCINE CONSENT FORM

PATIENT'S LAST NAME | PATIENT'S FIRST NAME | MI | GENDER (M/F) | BIRTH DATE | ETHNICITY (H / NH)

ADDRESS | CITY / STATE / ZIP | RACE (White, Black, American Indian/Alaskan Native, Asian,Native Hawaiin/Other Pacific Islander, Other)

PHONE NUMBER | MOTHER'S MAIDEN NAME

GENERAL HEALTH QUESTIONNAIRE

1. Are you sick today? __Yes __No
2. Do you have allergies to medications, food, vaccines, eggs, yeast, or latex? __Yes __No

   Allergies:
3. Have you ever had a serious reaction (anaphylaxis) after receiving an immunization or injectable therapy? __Yes __No
4. In the past 3 months, have you taken medications that weaken your immune system such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? __Yes __No
5. In the past 2 weeks have you tested positive for COVID-19, are you currently being monitored for COVID-19, or have you had contact with anyone who tested positive for COVID-19? __Yes __No
6. Have you had any of the COVID-19 symptoms in the past 2 weeks: fever/chills, cough, shortness of breath, muscle or body aches, new loss of taste or smell, sore throat, nausea or vomiting, or diarrhea? __Yes __No
7. For women: Are you pregnant or is there a chance you could become pregnant during the next month? __Yes __No

COVID-19 QUESTIONNAIRE (fill out if you are receiving the COVID-19 vaccine)

1. Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days? __Yes __No
2. Have you received any COVID-19 vaccines previously? If so, circle which one: Pfizer Moderna Johnson & Johnson __Yes __No

INFLUENZA QUESTIONNAIRE (fill out if you are receiving the Influenza vaccine)

1. Have you had a seizure or a brain or other nervous system problem or Guillain Barre? __Yes __No

CONSENT TO IMMUNIZE.

I have read, or have had read to me, the written information regarding the vaccine(s) being administered. I attest that I meet the criteria to receive the requested vaccination(s) as outlined by the Minnesota Department of Health. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and have received a copy of a current Vaccine Information Sheet. I certify that I am at least 18 years old and hereby give my consent to the pharmacists of this Mutual Member Drug Store to administer the vaccine(s). If under 18 years old, signature by parent or guardian is required. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Mutual Drug its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s).

SIGNATURE OF SELF OR LEGAL GUARDIAN | PRINT NAME | DATE

PHARMACY USE

PHARMACIST SIGNATURE/ TITLE | DATE/ DATE VIS GIVEN

	L R	IM Deltoid	LOT / MFGR
	L R	IM Deltoid	LOT / MFGR

GuidePoint Pharmacy
600 Sherman Ave
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