Covid-19
Medi-Thrift Pharmacy Immunization Consent Form

DAYSPATIENT'S LAST NAME	PATIENT'S FIRST NAME	MI	Gender (M/F)	MOTHER'S MAIDEN NAME
DATE OF BIRTH	ADDRESS	STATE/ZIP		PHONE NUMBER
AGE	INSURANCE (EX. MEDICARE, ETC)	ID NUMBER/MEDICARE NUMBER		SOCIAL SECURITY NUMBER
PRIMARY CARE PHYSICIAN		PRIMARY CARE PHYSICIAN CITY/STATE		***ALL INFORMATION IS REQUIRED BY GEORGIA STATE LAW VACCINE REPORTING REQUIREMENTS

CASE HISTORY AND LISTED CONTRAINDICATIONS (Please circle YES, NO, or DON'T KNOW for each question)	
Have you had a physical within the past year?	YES NO DON'T KNOW
Have you received a dose of the Covid-19 vaccine? If yes: ◯ Pfizer ◯ Moderna ◯ Other product	YES NO DON'T KNOW
Are you sick today?	YES NO DON'T KNOW
Have you received any vaccine within the last 14 days? **If yes, you cannot get this vaccine, you must wait 14 days.**	YES NO DON'T KNOW
Have you had a positive test for Covid-19 or has a doctor ever told you that you had Covid-19? **If yes, you can wait 30 to 90 days to vaccinate.**	YES NO DON'T KNOW
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for Covid-19? **IF YES, MUST WAIT 90 DAYS TO VACCINATE!**	YES NO DON'T KNOW
Do you have allergies to medications, eggs or other food, a vaccine component, or latex?	YES NO DON'T KNOW
If yes, list allergies.	
Have you ever had a serious reaction after receiving a vaccination or to any product? ◯ Was the severe allergic reaction after a Covid-19 vaccine? ◯ Was the severe allergic reaction to another vaccine or injectable medication?	YES NO DON'T KNOW
Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder?	YES NO DON'T KNOW
Do you have cancer, leukemia, HIV/AIDS or any other immune system problem or take any medications that may weaken your immune system?	YES NO DON'T KNOW
Have you had a seizure, brain disorder, Guillian-Barre Syndrome or other nervous system problem?	YES NO DON'T KNOW
Do you take any medication to thin your blood or have a bleeding disorder?	YES NO DON'T KNOW
Are you pregnant or breastfeeding?	YES NO DON'T KNOW

Current Medications
NOT REQUIRED

Covid-19

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I certify that I am: (a) the patient and at least 18 years of age; or (b) the parent or legal guardian of the patient ('Ward'). I have received a copy of the applicable Vaccine Information Statement[s] and have been given the Emergency Use Authorization (EUA) for the Covid-19 vaccine and I have read the adverse reactions associated with the administration of vaccine[s]. Furthermore, I consent to the administration of the vaccine[s] requested above to me or my Ward and acknowledge that, as a condition to administration of the vaccine[s], myself or my Ward must remain under the observation of the administering pharmacist for a period of not less than 15 minutes. I understand that a copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about the immunization[s]. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization[s] or the receipt of the immunization[s] by the person named above for whom I am the Ward. My medical record, may be shared with my primary care provider or other healthcare provider and the medical record of my Ward may be shared with his/her primary care provider or other healthcare provider. I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives and assigns, hereby release Medi-Thrift INC, and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt by my Ward of this or these immunization[s]. Neither Medi-Thrift INC nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccine[s] described above. I authorize Medi-Thrift Pharmacy to (a) notify my or my Ward's primary care provider of the vaccine administered and to provide same with copies of all vaccination records; (b) to enter my or my Ward's vaccine information on the Georgia Registry of Immunization Transactions; and (3) make any other disclosures required by law. Medi-Thrift Pharmacy will use and disclose your personal and health information or the personal and health information of your Ward, to receive payment of the care we provide, and for other health care operations. Healthcare operations generally include those activities performed to improve the quality of care. I acknowledge that I have received a copy of the Notice of Privacy Practices.

SHOT 1

SIGNATURE/LEGAL GUARDIAN **DATE OF VACCINATION/VIS/EAU GIVEN**

PRINTED NAME

SHOT 2

SIGNATURE/LEGAL GUARDIAN **DATE OF VACCINATION/VIS/EUA GIVEN**

PRINTED NAME

ADMINISTRATIVE RECORD (For Pharmacy Use ONLY)				
Vaccine/Date/Dose/ Manufacturer/Lot/ Expiration **SHOT 1**		Deltoid L R	DATE NEXT VACCINE DUE (IF APPLICABLE):	DATE M.D. NOTIFIED
ADMINISTERING PHARMACIST INFORMATION				
Shot 1 **PHARMACIST NAME/LICENSE NUMBER**			Medi-Thrift Pharmacy 324 W. Patton Street LaFayette, GA 30728 Phone: 706-638-3114	
ADVERSE EVENTS/COMPLICATIONS & NOTES (REPORT TO VAERS)				