Recipient Name:_____Date:_____

Email_____Date of Birth:_____

Address:_____

City:_____State:PA_____ZipCode:_____

Phone Number:_____

I declare that I am over the age of 18.
I further declare that:

1. I have not experienced anaphylaxis (difficulty breathing) or severe allergic reactions from a previous vaccination or an injectable medication.
2. 2. I have not had any other vaccinations in the previous 14 days (e.g. MMR, Shingrex, Varicella, or a TB skin test).
3. 3. I am not currently sick with a fever, active respiratory infection or other moderate/severe illness.
4. 4. I have not received monoclonal antibodies or convalescent plasma for treatment of COVID-19 within the past ninety (90) days.
5. 5. I have been given the opportunity to review and am not allergic to the ingredients in the COVID-19 vaccine.

**I understand that if I have any of the above conditions, I could be at increased risk of having a negative reaction or problem from the vaccine.**

**I further declare that if I have any of the following conditions,**
**I have spoken with my primary care provider and am making an informed decision to receive the vaccine:**

1. Pregnant, attempting to become pregnant or breastfeeding;
2. Have a bleeding disorder or are on a blood thinner;
3. Are immunocompromised or are taking a medication that affects the immune system (such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; HIV/AIDS, cancer, leukemia, ankylosing spondylitis or radiation treatments).

I agree to WAIT near the clinic location for 15 minutes after receiving the vaccine. If I have previously had a severe allergic reaction to a vaccine or injectable medication, I agree to WAIT near the clinic location for 30 minutes after receiving the vaccine.
I understand that the COVID-19 vaccine is a two-part vaccine series. By signing this consent, I am agreeing that I will receive the first and second part of the vaccine series.
I understand that the common risks associated with the COVID-19 vaccine include, but are not limited to, pain, redness or swelling at the site of injection, tiredness, headache, muscle pain, chills, joint pain, fever, nausea, feeling unwell or swollen lymph nodes (lymphadenopathy).
I understand that the vaccine may cause a severe allergic reaction which can include anaphylaxis (difficulty breathing), swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness and/or weakness.
I understand that these may not be all the side effects of the COVID-19 vaccine as the vaccine is still being studied in clinical trials. I also understand that it is not possible to predict all possible side effects or complications which could be associated with the vaccine. I understand that the long term side effects or complications of this vaccine are not known at this time.
I understand that the vaccination is being given by Rameshrx Pharmacy and its affiliates (collectively Rameshrx Pharmacy). The owner and/or operator of this site, their affiliates, officers, directors, employees and agents expressly disclaim any responsibility for the vaccination. My consent is given in light of this knowledge, and in consideration of Rameshrx Pharmacy giving the COVID-19 vaccine.
I, for myself and my heirs, administrators, trustees, executors, assigns and successors in interest

do hereby agree to release and hold harmless Rameshrx Pharmacy, its subsidiaries, divisions, affiliates, successors, assigns, officers, trustees, employees, volunteers and agents from and against any and all demands, damages, losses, costs, expenses, obligations, liabilities, claims, actions and cause of action (whether any of which is groundless or otherwise) of any nature whatsoever (including, without limitation, reasonable attorney's fees and court costs) by reason of or resulting, in any way, from any and all acts, accidents, events, occurrences, omissions and the like related to, or arising out of, directly or indirectly, my receipt of this COVID-19 vaccine. Rameshrx Pharmacy makes no warranties, express or implied, including but not limited to, implied warranties of merchantability or fitness for a particular purpose regarding the vaccine or its effectiveness.
I acknowledge receipt of Rameshrx Pharmacy's Notice of Privacy Practices.

Medicare Part B Recipients: I understand Rameshrx Pharmacy will process Medicare Part B claims on my behalf and accepts Medicare payment in full. I understand I must present my Medicare card prior to receiving the vaccine. I understand that if I have assigned my Medicare benefits to a Medicare Advantage Plan (like an HMO or PPO), I must receive my COVID-19 vaccine shot from my HMO/managed care provider or pay the Rameshrx Pharmacy charge.
Private Insurance Participants: If I have private insurance, I understand that Rameshrx Pharmacy will bill my insurance carrier on my behalf, and that I am responsible for paying the required fee for this vaccine to Rameshrx Pharmacy and for pursuing reimbursement from my health insurance carrier. Rameshrx Pharmacy cannot guarantee that this service will be reimbursable by insurance.
I have read and understood "What To Do If You Have A Reaction To The COVID-19 Vaccination" and the "Fact Sheet" by the FDA regarding the COVID-19 Vaccination. I further understand and agree that Rameshrx Pharmacy is required to submit COVID-19 vaccine administration data to the Pennsylvania Immunization Information System (PA-SIIS), and report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS).

I understand and agree to all of the above and I hereby give my consent to the staff of Rameshrx Pharmacy to give me a COVID-19 vaccine.

Recipient:_____Date:_____

Parent/Guardian/Designated
DecisionMaker:_____Date:_____

FOR PHARMACY USE ONLY: RECIPIENTS'S TEMPERATURE:_____

| VACCINE NAME | Manufacturer | LOT. No | Exp.Date | Dosage | Site | Date of EUA |
|---|---|---|---|---|---|---|
| | | | | | | |

Vaccinator :_____ Date:_____

# Prevaccination Checklist for COVID-19 Vaccines

## For vaccine recipients:

**Patient Name** _____

**Age** _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

| | Yes | No | Don't know |
|---|---|---|---|
| **1.** Are you feeling sick today? | | | |
| **2.** Have you ever received a dose of COVID-19 vaccine? | | | |
| • If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Another product _____ | | | |
| **3.** Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) | | | |
| • A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures | | | |
| • Polysorbate | | | |
| • A previous dose of COVID-19 vaccine | | | |
| **4.** Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) | | | |
| **5.** Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies. | | | |
| **6.** Have you received any vaccine in the last 14 days? | | | |
| **7.** Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? | | | |
| **8.** Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? | | | |
| **9.** Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? | | | |
| **10.** Do you have a bleeding disorder or are you taking a blood thinner? | | | |
| **11.** Are you pregnant or breastfeeding? | | | |

**Form reviewed by** _____ **Date** _____



Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists