Name: ____ Apt #: ______________ DOB: ____________

Potential Contraindications – Pre-vaccination Screening. To be completed on vaccination date.

		YES	NO	NOT SURE
1.	Are you feeling sick today? Do you currently have a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of sense of taste or smell, sore throat, nausea, vomiting or diarrhea?	☐	☐	☐
2.	Have you tested positive for COVID-19 in the past 21 days?	☐	☐	☐
3.	Have you ever had a dose of COVID-19 Vaccine?	☐	☐	☐

If yes:
Date of Vaccine: / / |Dose: ☐1st ☐ 2nd | Vaccine: ☐ Pfizer ☐ Moderna ☐ Another Product:

		YES	NO	NOT SURE
4.	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 hived, swelling, or respiratory distress, including wheezing.)			
	• A previous dose of COVID-19 vaccine	☐	☐	☐
	• Another vaccine or injectable medication	☐	☐	☐
	• Polyethylene Glycol *(AKA: PEG found in some medications, such as laxatives and preparations for colonoscopy procedures)*	☐	☐	☐
	• Polysorbate	☐	☐	☐
	• Any component of the COVID-19 vaccine (please see component information provided to you)	☐	☐	☐
5.	Have you received any vaccine in the last 14 days?	☐	☐	☐
6.	Have you received passive antibody therapy such as monoclonal antibodies or convalescent plasma serum as part of a COVID-19 treatment in the past 90 days?	☐	☐	☐
7.	Do you have a weakened immune system caused by something such as HIV infection or cancer?	☐	☐	☐
8.	Do you currently take medications that can diminish your immune response? (i.e., HIV medications, steroids, anticancer drugs, or radiation treatment, etc.?)	☐	☐	☐
9.	Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
10.	Women: Are you currently pregnant or breastfeeding? If YES: ☐ Check here to attest that you have consulted with your primary care provider and/or Obstetrician and/or Gynecologist and they have advised for you to receive the COVID-19 vaccination.	☐	☐	☐

CONSENT FOR SERVICES **1** I agree to WAIT at the designated 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 at the designated location for 30 minutes after receiving the vaccine. **2** 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, unless my primary care provider and/or other provider tells me otherwise. **3** 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. **4** I understand that the vaccination is being given by Centennial Pharmacy Services, Incorporated (Centennial) and its affiliates (collectively Centennial). The owner/operator of your chosen clinic site, their affiliates, officers, directors, employees, volunteers, and agents expressly disclaim any responsibility for the vaccination. My consent is given in light of this knowledge, and in consideration of Centennial 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 Centennial Pharmacy Services, Incorporated, 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. Centennial 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 Centennial's Notice of Privacy Practices. 5 I have received the Vaccine Information Sheet(s), Emergency Use Authorization Fact Sheet(s), and/or patient fact sheet corresponding to the COVID-19 Vaccination I am going to receive. I further understand and agree that Centennial is required to submit COVID-19 vaccine administration data to the Pennsylvania Immunization Information System (PA-SIIS), Philadelphia Immunization Information System (PhilaVAX), and report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS). **6** I understand and agree to all of the above and I hereby give my consent to the staff of Centennial Pharmacy Services, Incorporated to give me a COVID-19 vaccine. **7** If I am receiving a vaccine through a vaccine clinic, I understand that my name, and vaccine appointment date and time may be provided to the clinic coordinator.

Signature of Patient Date

RX AND VACCINE INFORMATION FOR IMMUNIZER AND CENTENNIAL USE ONLY

Vaccine	MVX	CVX	Dose
☐ Moderna, COVID-19 Vaccine, 100mcg/0.5mL	MOD	207	☐ 1st Dose ☐ 2nd Dose
☐ PfizerBioNTech, COVID-19 Vaccine, 30 mcg/0.3 mL	PFR	208	☐ 1st Dose ☐ 2nd Dose

Exp Date	Lot #	Site	Arm	Route
		☐ Deltoid (*preferred)	☐ Right ☐Left	Intramuscular (IM)

Was Patient Counseled on Potential Contraindications?

☐ Yes ☐No Contraindications Notes:

Immunizer

☐ Dr. Joseph Dymowski, Pharm. D – 1659735368
☐ Eileen Olimpo, RPh – 1750912580
☐ Michael McKinnon, RPh – 1720584055
☐ Oreste Olimpo, RPh – 1861901068
☐ Dr. Lucas Shumaker, Pharm. D – 1447557133
☐ Michele Logan, RN – RN599508

☐ Name: ______________________ License: ______________________

Date	Signature of Lead Pharmacist
	FOR STUDENTS ONLY