

Minor Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you tested positive for COVID-19 in the past 21 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a dose of COVID-19 Vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes: Date of Vaccine:    /    /      Dose: <input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup>   Vaccine: <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Another Product:			
4. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] <b>that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital?</b> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Another vaccine or injectable medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Polyethylene Glycol (AKA: PEG found in some medications, such as laxatives and preparations for colonoscopy procedures)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Polysorbate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Any component of the COVID-19 vaccine (please see component information provided to you)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you received any vaccine in the last 14 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have a weakened immune system caused by something such as HIV infection or cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you currently take medications that can diminish your immune response? (i.e., HIV medications, steroids, anticancer drugs, or radiation treatment, etc.?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Women: Are you currently pregnant or breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES: <input type="checkbox"/> 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 declare that I am the legal patient or guardian of the above-named patient, herein labeled as 'my child.' 2 I agree to have my child WAIT at the designated location for 15 minutes after receiving the vaccine. If my child has previously had a severe allergic reaction to a vaccine or injectable medication, I agree to have my child WAIT at the designated location for 30 minutes after receiving the vaccine. 3 I understand that the COVID-19 vaccine is a two-part vaccine series. By signing this consent, I am agreeing that I will have my child receive the first and second part of the vaccine series, unless my child's primary care provider and/or other provider tells me otherwise. 4 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. 5 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 for my child, to receive this COVID-19 vaccine is given in light of this knowledge, and in consideration of Centennial giving the COVID-19 vaccine. I, for my child, my child's heirs, myself, my heirs, myself and my child's 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 child's 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. 6 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 my child is 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). 7 I understand and agree to all of the above and I hereby give my consent to Centennial Pharmacy Services, Incorporated to give my child, the above-named patient, a COVID-19 vaccine. 8 If my child is receiving a vaccine through a vaccine clinic, I understand that my child's name, and vaccine appointment date and time may be provided to the clinic coordinator.

Name of Minor Patient Receiving the Vaccine	Date of Birth
Name of Parent or Guardian	Relationship to Minor Patient
Signature of Parent or Guardian	Date

**RX AND VACCINE INFORMATION FOR IMMUNIZER AND CENTENNIAL USE ONLY**

Vaccine	MVX	CVX	Dose
<input type="checkbox"/> PfizerBioNTech, COVID-19 Vaccine, 30 mcg/0.3 mL	PFR	208	<input type="checkbox"/> 1 Dose <input type="checkbox"/> 2 Dose
Exp Date	Lot #	Site	Route
		<input type="checkbox"/> Deltoid (*preferred)	<input type="checkbox"/> Right <input type="checkbox"/> Left Intramuscular (IM)
Was Patient Counseled on Potential Contraindications?			
<input type="checkbox"/> Yes <input type="checkbox"/> No Contraindications Notes:			
Immunizer			
<input type="checkbox"/> Dr. Joseph Dymowski, Pharm. D – 1659735368		<input type="checkbox"/> Oreste Olimpo, RPh – 1861901068	
<input type="checkbox"/> Eileen Olimpo, RPh – 1750912580		<input type="checkbox"/> Dr. Lucas Shumaker, Pharm. D – 1447557133	
<input type="checkbox"/> Michael McKinnon, RPh – 1720584055		<input type="checkbox"/> Michele Logan, RN – RN599508	
<input type="checkbox"/> Other:			