HAGUE PHARMACY

COVID-19 VACCINATION-STUDENT CONSENT & SCREENING FORM

Name: ____
Last First Middle

Date of Birth:_____/_____/_____ **Age:**______ **Gender:** ☐ M ☐ F **Hispanic/Latino** ☐ Yes ☐ No

Race: ☐American Indian/Alaskan Native ☐ Asian ☐Black or African American ☐Hawaiian Native or Other Pacific Islander ☐ White ☐Not Stated

If minor - parent/guardian's name & date of birth ______________________________ ______________
Last First M.I. Date of birth mm/dd/yyyy

Address:______________________________City/State:________________ZIP:____________

Grade:_______ **Home Room Teacher:**_________________________**School:**____________________

IMPORTANT Parent/Guardian Phone # Home:________________Cell:________________Work: ________________

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

Hague Pharmacy is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If a health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.
2. If you should be directly exposed to blood or body fluids of a Hague Pharmacy health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the tests.
3. A physician or other health care provider will tell you and that person the result of the tests.

I have read the Emergency Use Authorization Fact Sheet for the COVID-19 vaccine and understand the risks and benefits. I believe the benefits outweigh the risks, and I accept full responsibility for any reactions that may result from the receipt of the immunization. I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the COVID-19 vaccine.

Office of Privacy and Security - Authorization for Disclosure of Protected Health Information

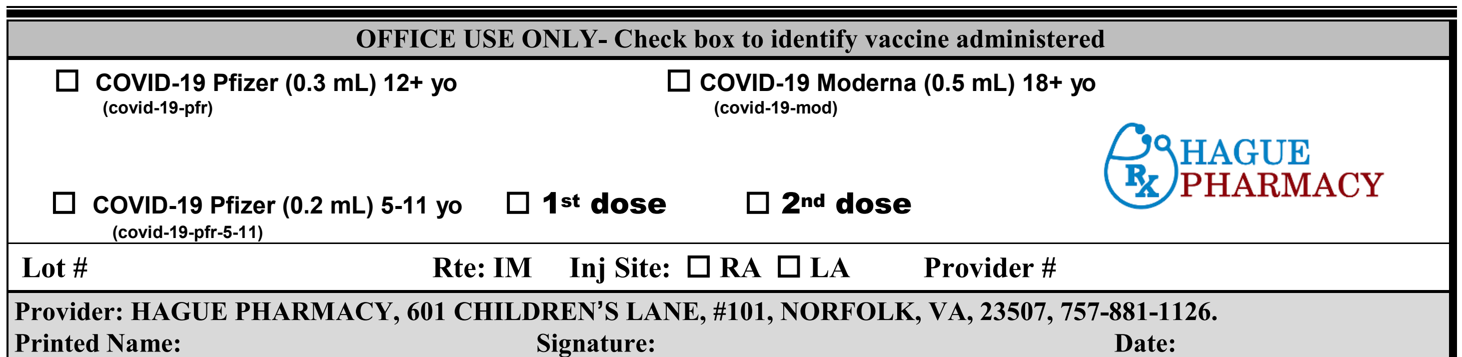
This consent gives the Virginia Department of Health (VDH) & Hague Pharmacy permission to disclose personal health information to the person(s) or organization(s) I have indicated.

- I understand the provision of treatment to my child cannot be conditioned on my signing of this authorization.
- Any health information redisclosed by me or my child will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included with my child's medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize VDH & Hague Pharmacy to disclose my child's health information to his/her primary care physician and school.
- I understand that this record will be retained until my child reaches 21 years of age.
- I understand this document will be given to and retained by VDH and will not be maintained by the school.

❑ Please check box if you wish to receive a copy of the Virginia Department of Health Privacy Rights

X
Patient, Parent/Legal Guardian, Person Acting in Loco Parentis-Printed Name Signature Date

************PARENTS – PLEASE COMPLETE THE SCREENING QUESTIONNAIRE ON BACK************



OFFICE USE ONLY- Check box to identify vaccine administered

☐ **COVID-19 Pfizer (0.3 mL) 12+ yo** (covid-19-pfr)

☐ **COVID-19 Moderna (0.5 mL) 18+ yo** (covid-19-mod)

☐ **COVID-19 Pfizer (0.2 mL) 5-11 yo** (covid-19-pfr-5-11) ☐ **1st dose** ☐ **2nd dose**

Lot # **Rte: IM** **Inj Site:** ☐ **RA** ☐ **LA** **Provider #**

Provider: HAGUE PHARMACY, 601 CHILDREN'S LANE, #101, NORFOLK, VA, 23507, 757-881-1126.
Printed Name: **Signature:** **Date:**

Pre-vaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

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.

Name: ______________________

Age: __________

	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- BioNtech ☐ Moderna ☐ Janssen (Johnson and Johnson)			
• Have you received a complete COVID-19 vaccine series? *(i.e., 1 dose Janssen or 2 doses of an mRNA vaccine [Pfizer-BioNTech, Moderna]*)	☐	☐	
• Did you bring your vaccination record card or other documentation?	☐	☐	
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 caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including either of the following: ○ Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• 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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

5. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or a medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ History of Guillain-Barré Syndrome (GBS)

Form reviewed by ______________________ Date ______________