BEACON PRESCRIPTIONS

COVID-19 Vaccination Intake form

Name of Child: _____ Name of Guardian: _____

Social Security Number: _____

Date of birth: _____

Phone number: _____

Address: _____ Town: _____ Zip: _____ State : _____

Guardian Email: _____

Name of Primary Insurance: _____

Insurance ID number: _____

Group number: _____ / PCN Number: _____

Subscriber's name: _____

Subscriber's relationship to patient: _____

Sex: _____

Race: _____

Ethnicity: _____

Any Health Conditions: _____

FOR OFFICE USE ONLY

Date of Vaccination:		Location of Injection:
Individual administering vaccine:		Left Arm / Right Arm
Vaccination Lot Number:		

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 ☐ Janssen (Johnson & Johnson) ☐ 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 a COVID-19 vaccine including either of the following:			
o Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
o Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
• A previous dose of COVID-19 vaccine.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
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, or any vaccine or injectable medication? This would include food, pet, venom, 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?			
12. Do you have dermal fillers?			

Form reviewed by _____ **Date** _____

Pfizer-BioNTech COVID-19 Vaccine Consent and Screening Form for Individuals Under 18 Years of Age

Section 1: Information About Minor Child to Receive Vaccine (please print)

MINOR'S NAME (Last)	(First)	(M.I.)	**MINOR'S DATE OF BIRTH (MM/DD/YEAR):** _____	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	**MINOR'S AGE:**	**MINOR'S GENDER: M/F**
ADDRESS			**PARENT/GUARDIAN DAYTIME PHONE NUMBER AND MOBILE NUMBER:**	
CITY	**STATE**	**ZIP**		

Section 2: Screening for Vaccine Eligibility

The following questions will help us determine if there is any reason your child should not get the COVID-19 vaccine. If you answer "yes" to any question, it does not necessarily mean that your child 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	UNKNOWN
1. Is your child currently feeling sick or ill?			
2. Has your child ever received a dose of the COVID-19 vaccine? If yes, which vaccine? ☐ Moderna; ☐ Pfizer; ☐ Johnson & Johnson; ☐ another brand of vaccine: _____			Date: _____ (*If applicable*)
3. Has your child 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 your child 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 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?			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction?			
4. Has your child 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 your child 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. Has your child ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Has your child received any vaccine in the last 14 days?			
7. Has your child ever had a positive test for COVID-19 or has a doctor ever told you that your child had COVID-19?			

8. Has your child received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Does your child have a weakened immune system caused by something such as HIV infection or cancer or does your child take immunosuppressive drugs or therapies?			
10. Does your child have a bleeding disorder or is your child taking a blood thinner?			
11. Is your child pregnant or breastfeeding?			
12. Does your child have dermal fillers?			

Section 3: Information on the risks and benefits of the PfizerBioNTech COVID-19 Vaccine

The Pfizer-BioNTech COVID-19 Vaccine may prevent the person vaccinated from getting COVID-19. There is no U.S. Food and Drug Administration (FDA)-approved vaccine to prevent COVID-19. However, the FDA has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine to prevent COVID-19 in individuals twelve (12) years of age and older under an Emergency Use Authorization (EUA). The Pfizer-BioNTech COVID-19 Vaccine is administered as a 2-dose series, 3 weeks apart, into the muscle.

The Pfizer-BioNTech COVID-19 Vaccine may not protect everyone. Side effects that have been reported with the Pfizer-BioNTech COVID-19 Vaccine include injection site pain, tiredness, headache, muscle pain, chills, joint pain, fever, injection site swelling, injection site redness, nausea, feeling unwell, and swollen lymph nodes. There is a remote chance that the Pfizer-BioNTech COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the Pfizer-BioNTech COVID-19 Vaccine. For this reason, a vaccination provider may ask the person receiving the vaccine to stay at the place where they received their vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include difficulty breathing, swelling of the face and throat, a fast heartbeat, and/or a bad rash all over the body.

Section 4: Consent

I have reviewed the information on risks and benefits of the Pfizer-BioNTech COVID-19 Vaccine in Section 3 above and understand the risks and benefits. In providing my consent below, I agree that:

1. I have reviewed this consent and screening form.
2. I have read or had read to me the latest (i.e. most recently released) version of the FACT SHEET FOR RECIPIENTS AND CAREGIVERS; EMERGENCY USE AUTHORIZATION (EUA) OF THE PFIZER-BIONTECH COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 12 YEARS OF AGE AND OLDER, available at https://www.cvdvaccine.com/ or https://www.fda.gov/media/144414/download.
3. I have the legal authority to consent to have the minor child named above vaccinated with the Pfizer-BioNTech COVID-19 Vaccine.
4. I understand that I am not required to accompany the child named above to their vaccination appointment and that, by giving my consent below, the child may receive the Pfizer-BioNTech COVID-19 Vaccine whether or not I am present at the vaccination appointment.
5. If I have health insurance that covers the child named above, I give permission for my insurance company to be billed for the costs of administering the PfizerBioNTech COVID-19 Vaccine. The government is paying for the Pfizer-BioNTech COVID-19 Vaccine itself, and I will not be billed for that portion of the cost of my immunization.
6. I understand that pursuant to state law, all immunizations will be inputted to the Louisiana Immunization Network (LINKS) registry operated by the Louisiana Department of Health. More information about LINKS can be found at https://ldh.la.gov/index.cfm/page/3660.

I GIVE CONSENT to _____ [INSERT VACCINATING ENTITY NAME] to vaccinate the minor child named at the top of this form with the Pfizer-BioNTech COVID-19 Vaccine and have reviewed and agree to the information included in Section 4 of this form.

_____

Signature of the Parent/Legal Guardian named above

Date Signed: month_____ day_____ year_____

BEACON PRESCRIPTIONS®

Patient Acknowledgement Form For COVID-19 Vaccination

I understand and agree to the following as part of my receiving the COVID-19 vaccine from Beacon Prescriptions:

- There is no co-payment or out-of-pocket expense to me.
- Beacon Prescriptions has received the vaccine at no cost and will not submit any bills or invoices seeking payment for the cost of the vaccine.
- I agree and consent to receive the COVID-19 vaccine and acknowledge that the risks, benefits, and alternatives have been explained to my satisfaction. I understand the COVID-19 vaccine has the potential side effects. I understand there is a remote risk of more severe or unexpected side effects. I understand that the emergency use of the COVID-19 vaccine has been authorized by the United States Food and Drug Administration (FDA) under an Emergency Use Authorization (EUA).
- I permit Beacon Prescriptions to obtain payment for administering the vaccine to me. I understand and agree to the following provisions.

  Release of confidential information: I understand that my health care information is confidential and is protected from disclosure by law, but that it may be used for treatment, payment for services provided, and healthcare operations.
  Release to insurer: I understand that Beacon Prescriptions and/or any physician entity, or organization providing medical services may release information to my insurance carrier(s) to substantiate payment for medical care or services, or employers (and/or their insurance carriers) in Workers' Compensation matters. Such persons or entities are permitted to examine and obtain necessary information from my medical records in accordance with application law related to patients' confidential health information and the Medical Records policies of Beacon Prescriptions.
  Assignment of benefits: I assign to Beacon Prescriptions and/or any physician, entity, or organization providing medical services to me any and all benefits, including payment, to which I may be entitled. Payments include those from any government agency, insurance carrier, or others financially responsible for the medical care rendered to me or my dependent.
  Appeal: I agree that Beacon Prescriptions may appeal any disallowance of payment by my insurance company for medical care rendered.
  Provisions specific to individuals with Medicare Insurance: I certify that the information I have provided for purposes of applying for payment under Title XVIII of the Social Security Act is accurate. I understand that any holder of my medical or other information regarding my treatment may release to the Social Security Administration and/or the Centers for Medicare and Medicaid Services, or its intermediaries or carriers, any necessary information needed in relation to a Medicare claim. In relation to a Medicare claim, I request that payment of authorized benefits be made on my behalf. I assign the Medicare benefits payable for physician services to the physician, entity, or organization furnishing the services or authorize such physician, entity, or organization to submit a claim to Medicare on my behalf.

Patient Signature or Responsible Person _____ Date/Time _____

Responsible Person's relationship to patient (if applicable) _____