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33 Main St, Centerbrook, CT 860-767-1389
23 Killingworth Rd , Higganum, CT 860-345-3607
3 N. Second Avenue, Taftville, CT 860-383-2013
38 William F Palmer Rd, Moodus ,CT 860-891-8142
345 Broad St. New London,CT 860-910-4909

Covid-19 Vaccine Consent and Administration Record

Pharmacist Immunization Program

Information about patient receiving vaccination (Please print):

Last Name	First Name	Middle Init.	Date of Birth	Sex
Street		City	State Zip	Phone #
Medical Condition(s)			Allergies	
Primary Care Physician (PCP)			PCP Contact Information	

Primary Insurance:	Cardholder Name:	Cardholder ID#:	Medicare #:	BIN #: PCN: RX Grp:

Please answer the following questions	YES	NO	DON'T KNOW
1. Are you sick today? (For example: a cold, fever or acute illness)	☐	☐	☐
2. Do you have allergies or reactions to any foods, latex, medications, or vaccines? (For example: Covid-19, eggs, Polyethylene glycol (PEG), gelatin, neomycin, thimerosal, etc.) List_____	☐	☐	☐
3. Do you take anticoagulation medication? (For example: warfarin, Coumadin or other blood thinner)	☐	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorder?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?	☐	☐	☐
6. Have you ever received a dose of Covid-19 Vaccine?	☐	☐	☐
7. Have you had a seizure, brain, or nervous system problem? (For example: Guillain-Barré syndrome)	☐	☐	☐
8. During the past year, have you received a transfusion of blood products, or been given immune (gamma) globulin or antiviral drug?	☐	☐	☐
9. For women: Are you pregnant or nursing? Could you become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

Please read the following statements and sign on the signature line below

CONSENT FOR SERVICES, MEDICAL RECORDS AND HIPAA PRIVACY INFORMATION

I have been provided with the Vaccine Information Sheet corresponding to the vaccine(s) that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

I voluntarily authorize and direct my health care provider at to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at Nutmeg Pharmacy (standing order provider _____), my Primary Care Physician (PCP), my insurance plan and/or state or federal registries, where required, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). This authorization permits Nutmeg Pharmacy to disclose the following medical records: only documents related to the vaccination(s) received today. This Authorization will remain in effect until my health care provider discloses my health information to the recipient identified above; my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by the Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such a refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Medicare Billing: I do hereby authorize Nutmeg Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

X_____ **Date:**_____

Signature of patient to receive vaccine or person authorized to make the request (parent/guardian)

VACCINE ADMINISTRATION INFORMATION:

Date	Product	Manufacturer	Vol (ml)	Route
_____	**Covid-19 Vaccine**	☐ Pfizer	0.3	IM Deltoid **L / R**

Lot#	Exp. Date	VIS/EUA Version Date	Date VIS Given to Pt	Administering Immunizer Name & Title
ER8729	7/21	3/26/2021		