COVID-19 VACCINE CLINICS

12 years and older

Pfizer Vaccine

DATE	TIME	LOCATION	LINK TO REGISTER
Monday, August 30	2 – 5PM	Cabrillo High School 4350 Constellation Rd. Lompoc, CA 93436	https://kordinator.mhealthcoach.net/vcl/1629133705635
Tuesday, August 31	2 – 4PM	Vandenberg Middle School 1145 Mountain View Blvd. Vandenberg SFB, CA 93437	https://kordinator.mhealthcoach.net/vcl/1629134255332
Wednesday, September 1	2 – 5PM	Lompoc High School 515 West College Ave. Lompoc, CA 93436	https://kordinator.mhealthcoach.net/vcl/1629134813075
Thursday, September 2	2 – 5PM	Hapgood Elementary School 324 S. A Street Lompoc, CA 93436	https://kordinator.mhealthcoach.net/vcl/1629135100002
Friday, September 3	2 – 5PM	Lompoc Valley Middle School 234 S. N Street Lompoc, CA 93436	https://kordinator.mhealthcoach.net/vcl/1629135417509

ON THE DAY OF CLINIC, PLEASE BRING:

1. ID/Driver's license – if applicable.
2. Health insurance card
3. Completed consent form (see below as there is one specifically for minors)

Pfizer-BioNTech COVID-19 Vaccine Consent
For Individuals Under 18 Years of Age

Section 1: Information about the child to receive Pfizer-BioNTech COVID-19 Vaccine (please print):

Child's Name (Last, First, Middle) Date of Birth (mm/dd/yyyy) Age

Street Address City State Zip

Phone Number

Section 2: Information on the risks and benefits of the Pfizer-BioNTech COVID-19 Vaccine (Pfizer Vaccine).

Currently the U.S. Food and Drug Administration (FDA) has authorized emergency use of the Pfizer Vaccine to prevent COVID-19 in individuals 12 years of age and older. The FDA has not yet approved licensure of vaccine to prevent COVID-19. To learn more about risks, benefits, and side effects of the Pfizer vaccine, read the U.S. Food and Drug Administration's Fact Sheet for Recipients and Caregivers.

Section 3: Consent.

I have reviewed the information on risks and benefits of the Pfizer Vaccine in Section 2 above and understand the risks and benefits. I agree that:

1. I reviewed this consent form and have read and understand the "Fact Sheet for Recipients and Caregivers" about the potential risks and benefits of the Pfizer Vaccine.
2. I have the legal authority to consent to have the child named above vaccinated with the Pfizer Vaccine.
3. I understand I am not required to accompany the child named above to the vaccination appointment and, by giving my consent below, the child will receive the Pfizer Vaccine whether or not I am present at the vaccination appointment.
4. I understand that as required by state law (Health and Safety Code, § 120440), all immunizations will be reported to the California Immunization Registry (CAIR2). I understand the information in the child's CAIR2 record will be shared with the local health department and State Department of Public Health, shall be treated as confidential medical information, and shall be used only to share with each other or as allowed by law. I may refuse to allow the information to be further shared and can request the CAIR2 record be locked by visiting the Request to Lock My CAIR Record web form.

I GIVE CONSENT for the child named at the top of this form to get vaccinated with the Pfizer-BioNTech COVID-19 Vaccine and have reviewed and agree to the information included in this form.

Name (Last, First, Middle)

Signature Date

Address if different from above

Informed Consent for Immunization with COVID-19 Vaccine

❒M ❒F ❒Other

Last Name **First Name** **Middle** **Date of Birth** **Age** **Gender**

( ) -

Home Address **City** **State** **Zip** **Phone #** ❒**Home** ❒**Cell**

Medicare Part B ID#:_____ **Last 4 digits of SSN:** _____ **Driver's License #:**_____

Race: ❒Asian ❒ Black or African American ❒Hispanic ❒American Indian ❒Caucasian ❒Pacific Islander ❒Two or More ❒Other: _____
Ethnicity: ❒Hispanic or Latino ❒Non-Hispanic or Latino ❒Decline to State (Unknown)

Which arm do you prefer for vaccine? **(Please circle)** **Left** **Right** **Enter weight IF LESS than 66 pounds:** _____**Lbs.** **Primary Care Provider Name:** _____ **Primary Care Provider Address:** _____

Screening Questionnaire: *Please answer questions by checking the boxes.*

Screening Questions – NOTE: IF COMPLETED ONLINE, REVIEW ANSWERS WITH PATIENT TO ENSURE NO CHANGES		**Yes**	**No**
1.	Are you sick today?	❒	❒
2.	Have you ever received a dose of COVID -19 vaccine? If yes, which product did you receive? ❒ Pfizer ❒ Moderna ❒ Other: _____ Date: _____	❒	❒
3.	Have you ever had an allergic reaction to a previous COVID-19 vaccine or any component of the COVID-19 vaccine, including polyethylene glycol (PEG) or polysorbate?	❒	❒
4.	Have you ever had an allergic reaction to another vaccine (other than COVID-19) or to an injectable medication?	❒	❒
5.	Have you ever had a severe allergic reaction (anaphylaxis) to any food, pet, environmental allergens, oral medications, or latex? If yes, please list:	❒	❒
6.	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19 within the last 90 days?	❒	❒
7.	Are you pregnant or breastfeeding? (not a contraindication)	❒	❒

Informed Consent: Please read and sign.

By my signature below, I consent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist or technician, or other authorized person, where permitted by law or state/federal guidance, employed or contracted by Albertsons Companies or one of its affiliated pharmacies and to be contacted at the number provided above regarding other immunizations for which I am due or eligible to receive. The above information is true and correct. I attest I meet eligibility criteria for the vaccination (if any); if I am the parent/guardian of the minor patient, I attest the minor patient meets eligibility criteria for the vaccination. I also release Albertsons Companies and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting, or arising from my receipt of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination and understand that I am obligated to pay for all products and services received, if applicable. 2) I may be responsible for payment after the date of service if the product or service is billed to my medical benefit. 3) I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient. 4) I will immediately alert the pharmacist of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine. 5) I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects. 6) I should remain in the area for observation for 15 minutes unless I have a history of an immediate allergic reaction of any severity to a vaccine or injectable therapy or if I have a history of anaphylaxis due to any cause I should remain in the area for observation for 30 minutes after the vaccination. If I leave the area without waiting, I acknowledge that I am doing so at my own risk and against the advice of the professional who administered the vaccine. 7) I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization ("EUA") provided for the vaccine(s) to be administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). 8) I have been offered and/or provided a copy of the company's Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA). 9) This vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting by my pharmacy or its business associate to an immunization registry, which may share my immunization data with others, and to my primary care physician, the authorizing physician, or the local Department of Health, if applicable, and I authorize these disclosures. (*New Jersey Only: I authorize ___ do not authorize ___ reporting of my receipt of this vaccination to my primary care provider I understand that failure to check authorize/do not authorize will serve as authorization.*) *(South Dakota and Massachusetts only: I understand I have the right to object to the sharing of my data to the above-mentioned parties through such registries.)*

X

Signature of Patient or Parent/Guardian of Minor Patient **Date**

For Pharmacy Use Only

Vaccine Name	**Lot #**	**Expiration Date**	**Manufacturer**	**Dose (ml)**	**Dose #**	**Route**	**Site** (circle)	**VIS/EUA Publication Date**
							R / L Deltoid	

Name of Administrator: _____ **Administration Date:** _____ ❒ **NPP Offered** **RPh Counseling (Please circle):** **Accepted / Declined**

RPh Signature [Indicates (1) VIS/EUA Provided (2) Counseling Offered and (3) Patient Eligibility Verified]: _____

WA ONLY: Substitution Permitted:_____ **Dispense as Written:**_____

RxBIN: _____ PCN: _____ Group#: _____ ID#: _____

Medical (Name, ID#, Group#, Payer ID - if UHC): _____

Billing Info (off-site only) Clinic Name: _____ Clinic Address: _____