 Heartland Homecare Services, Inc.

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**COVID-19 Vaccine Consent Form**

Name (last, first): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_

Person getting shot: Staff \_\_\_ Resident: \_\_\_ Other: \_\_\_ Agency/Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Role: \_\_\_\_\_\_\_\_\_\_\_\_\_

Paid caregiver/parent: \_\_\_\_\_\_ non-paid caregiver/parent 65yrs or older: \_\_\_\_\_ Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: M or F Race: \_\_\_\_\_\_\_\_Ethnicity: \_\_\_\_\_\_\_\_\_\_ Mother’s Maiden Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider and address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Billing (attach copy of card, front and back):**

Policy Holder Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bin #\_\_\_\_\_\_\_\_ Insurance Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Screening Questions:**

1) Is this your first time receiving the COVID-19 vaccine? \_\_\_ Yes or \_\_\_ No; if no: date of first vaccine: \_\_\_\_\_\_\_\_\_\_\_\_

2) Have you had ANY side effects or adverse events to a COVID-19 vaccine? \_\_\_ Yes or \_\_\_ No

3) Have you had a severe allergic reaction to any vaccine or injectable medication? \_\_\_ Yes or \_\_\_ No

If yes, describe reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4) Have you ever had an anaphylactic reaction (shortness of breath, hives, throat swelling) \_\_\_ Yes or \_\_\_ No

to any substance?

5) Do you have a fever or feel ill today? \_\_\_ Yes or \_\_\_ No

6) Have you been diagnosed with COVID-19 within the last 14 days? \_\_\_ Yes or \_\_\_ No

7) Have you received antibody infusion within the last 90 days? \_\_\_ Yes or \_\_\_ No

8) Have you received any vaccine within the last 14 days? \_\_\_ Yes or \_\_\_ No

9) Females: Is there a chance you may be pregnant today? \_\_\_ Yes or \_\_\_ No

The pharmacist or Intern administering your vaccine will review your answers to the above questions prior to administration. The pharmacist will keep this form and any information collected in a confidential manner. A record of this vaccine administration will be provided to your primary care physician and KSWEBIZ as required by law. A pharmacist is available to answer questions at the time of administration or by calling the pharmacy number listed above.

**Informed Consent:**

I acknowledge that I have received and have read or had explained to me and understand the information on the “Fact Sheet for Recipients and Caregivers”. I have had the opportunity to ask questions and fully understand the benefits and risks of vaccination with the COVID-19 vaccine. I understand the Notice of Privacy Practices presented to me. My signature below indicates my permission for the COVID-19 vaccine to be given to me or the person named above for whom I am authorized to make this request. I consent to inclusion of this immunization in the Kansas Immunization Registry (WebIZ) for myself or on behalf of the person I represent named on this form.

Signature of individual to be vaccinated or authorized representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of signing individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy use only:** Vaccine: Janssen COVID-19

Lot: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp: \_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: 0.5mL IM in L or R deltoid on \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_

Adverse reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunized at:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Co-signature/title if required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Observation departure time: \_\_\_\_\_\_\_\_\_\_\_\_\_