| **Patient Information** | | | |
|---|---|---|---|
| Last Name (legal): | First Name (Legal): | MI: | Preferred Name: |
| Date of Birth: | Gender:(circle one)<br>Male or Female | Other Gender identify (if needed): circle one<br>Transgender M (F to M):<br>Transgender F (M to F):<br>Something else | |
| Ethnicity: | | | |
| Home Phone #: | Cell Phone #: | Reminder Calls or Texts (please circle one) | |
| Address: | City: | State: | |
| Email: | | | |

**Medical Arts Pharmacy COVID-19 Demographics and Questionnaire**
**Medical Arts Pharmacy 346 Maine Street Lawrence, KS 66044 Phone: (785) 843-4160**
**Fax: (785) 843-3214 www.medicalarts-rx.com**

| **Parent/Guardian information** | |
|---|---|
| Last Name: | First Name: |
| If different from information above | |
| Phone Number: | Address: |
| Email Address: | |

**Emergency Contact(s)**

Please list an individual(s) not living with you that we could contact in case of an emergency.

| Name | Relationship | Phone |
|---|---|---|
| | | |

I hereby state, to the best of my knowledge, the above information is complete and correct. I voluntarily consent to and authorize care, encompassing the COVID-19 vaccine or any other treatment deemed medically necessary by a Medical Arts Pharmacy pharmacist. I acknowledge and consent to receive both doses of the COVID-19 vaccine within the required timeframe, If I fail to keep my scheduled appointment, I acknowledge that the second appointment will be forfeited and will be rescheduled at a later time.

Signature_____ Date_____

Copy of Front and Back of Medicare Cards and/or supplemental insurance:

Copy of ID Front and Back (Driver's License,etc.)

| First Name: | Last Name: | Date of Birth: | |
|---|---|---|---|

| COVID-19 | Yes | No |
|---|---|---|
| In the past two weeks, have you tested positive for COVID-19? If yes, have you also been treated with passive antibody therapy (monoclonal antibodies or convalescent serum as treatment for COVID-19)? | | |
| In the past two weeks, have you had contact with anyone who tested positive for COVID-19? | | |
| Do you currently or have you in the past 14 days, had a fever, chills, cough, shortness of breath, difficulty breathing, fatigue. Muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea? | | |

| **Immunization Screening Questions** | Yes | No | Do not know |
|---|---|---|---|
| Are you sick today? (for example: a cold, fever or acute illness) | | | |
| Do you have allergies or reactions to any food, medications, vaccines, or latex? (example: eggs, gelatin, neomycin, thimerosal, etc.) | | | |
| Do you have allergies to an of the components of the Moderna COVID-19 vaccine? (Each dose of the Moderna COVID-19 Vaccine contains the following ingredients: a total lipid content of 1.93 mg (SM-102, polyethylene glycol [PEG] 2000 dimyristoyl glycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]) 0.31 mg tromethamine, 1.18 mg tromethamine hydrochloride, 0.043 mg acetic acid, 0.12 mg sodium acetate, and 43.5 mg sucrose.) **(including polysorbate)** | | | |
| Have you ever had a serious reaction after receiving a vaccination? Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a hospital setting? | | | |
| Have you had a seizure? Do you have a neurological disorder or history of Guillen Barre syndrome? | | | |
| Do you take anticoagulation medication? i.e., Warfarin, Coumadin, or other blood thinner. | | | |
| Do you have a long-term health problem such as heart disease, liver disease, asthma, kidney disease, metabolic disease, anemia, or any other blood disorders? | | | |
| Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, or any other immune system problem? | | | |
| Do you have a weakened immune system or in the past 3 months, taken medications the suppress your immune system such as cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments? | | | |
| During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? | | | |
| For women, are you pregnant or is there a chance you could become pregnant during the next month? | | | |
| Have you received any vaccinations or a TB skin text in the past four weeks? | | | |

# Moderna Covid-19 Vaccine Consent Form

I have received, read, and understand the COVID-19 Vaccine Information provided by Medical Arts Pharmacy. .I hereby authorize Medical Arts Pharmacy and the pharmacists employed by or contracted with Medical Arts Pharmacy to administer the Vaccine I have requested above as a two-dose regimen series administered 28 days apart. The scope of this consent includes discussion about the vaccine(s) and its administration between Medical Arts and other health care professionals for purposes of care and treatment. I understand that I may withdraw this consent at any time by making a request in writing.

I acknowledge that I have been informed about, the following:

- The goal of the Services is to administer the Vaccine I requested.
- The Provider(s) will provide me with additional information about any risks associated with the Services, which depend upon my specific diagnoses and health status.
- Administering Vaccines is not an exact science and there are no guarantees as to the results of the Services that may be provided to me.
- The nature and purpose of the Services, expected benefits, potential known and unknown complications, likelihood of achieving goals, and relative risks that may a rise from the Services, along with the relevant risks and consequences of no treatment.

I understand the benefits and risks of the Vaccine and I expressly consent, request, and authorize the administration of the Vaccine. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Medical Arts Pharmacy, each Provider and the applicable staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liability or claims, whether known or unknown, arising out of, in connection with, or in any way related to the Services.

I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registration ("State Registry") and my state's health information exchange ("State HIE"); and (b) the Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination.

I further authorize the applicable Provider to: (a) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to, or through, the State HIE to my healthcare professionals, Medicare, Medicaid, or other third-party payers as necessary to effectuate care or payment; (b) submit a claim to my insurer for the Services; and (c) request payment or authorized benefits be made on my behalf to the applicable Provider with respect to the Services.

I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the Provider: (a) the disclosure of my vaccination information by the Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The Provider will, If my state permits, provide me with an Opt-Out Form. I understand that I may need to consent, depending on my state's law, and to the extent so required, I hereby do consent by signing below to the Provider reporting my vaccination information to the State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent Form. Unless I provide the Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the Provider and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my vaccination information to or through the State HIE as required or permitted by law.

Photocopies/electronic transmissions/faxes of this consent and any signatures are to be considered as valid originals.

MY SIGNATURE BELOW INDICATES THAT I VOLUNTARILY AGREE TO ALL OF THE ABOVE AND THAT THE NATUREOF THIS CONSENT WAS EXPLAINED TO ME AND THAT I HAD THE OPPORTUNITY TO ASK ANY AND ALL QUESTIONS REGARDING THE ABOVE AND MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I UNDERSTAND THE BENEFITS AND RISKS OF THEVACCINE AND I EXPRESSLY CONSENT, REQUEST AND AUTHORIZE THE ADMINISTRATION OF THE VACCINE. I HAVE BEEN PROVIDED WITH THE CDC'S VACCINE INFORMATION SHEET(S) OR THE EMERGENCY USE AUTHORIZATION (EUA) PATIENT FACT SHEET CORRESPONDING TO THE VACCINE THAT I AM RECEIVING.

| Print Name (signatory): | Signature: | Date: |
|---|---|---|
| If patient is a minor, Guardian's Name: | | |
| Relationship to Patient if applicable: Spouse Power of Attorney Legal Guardian Other: | | |
| Witness (use if relationship to Patient is "Other"): (optional) | | |
| Signature: | Print Name: | |

| **Insurance Information** |
| --- |
| We will need a copy of the front and back of your insurance card and government issued ID. |
| Policy Holder Name: |
| Rx Bin # |
| Rx ID # |
| Other insurances you may have: (i.e., Medicare part A or B) |