

COVID-19 Immunization: Medicap Pharmacy/Medicus Urgent Care/VNA Hospice

Name: _____ Gender: M F O DATE: _____

Address: _____ Date of Birth: _____

Phone: _____ E-mail _____

Ethnicity/Race : Arabian; Asian Indian; Black; Chinese; Filipino; Indian; Japanese; Korean; Thailander; Vietnamese;
White; Cuban; Mexican; Puerto Rican; South or Central American; Unknown Prefer not to Answer; Other: _____
Hispanic; Non-Hispanic;

Eligibility: Essential Worker First Responder; Healthcare Worker; ≥65 years old;
Group Home Resident/long-term care facility/Assisted Living Patient with underlying condition age 16-64; N/A

Screening Questionnaire for Immunization:

1	CHECK: <input type="checkbox"/>FIRST Covid 19 VACCINE or <input type="checkbox"/>SECOND Covid 19 VACCINE; if second, check 1st vaccine given <input type="checkbox"/>Moderna <input type="checkbox"/>Pfizer <input type="checkbox"/>other		
2	Are you sick today?	Yes	No
3	In the past 2 weeks have you tested positive for COVID-19 or has your doctor ever told you that you had COVID-19? Date of Positive test: _____	Yes	No
4	Have you received any other vaccine in the past 14 days? Which one? _____	Yes	No
5	Have you received COVID-19 Monoclonal antibodies or convalescent serum in the past 90 days?	Yes	No
6	Do you have any allergies to these components of the COVID 19 vaccine? polyethylene glycol or polysorbate	Yes	No
7	Do you have any vaccine, drug or food allergies that caused anaphylaxis which required an epi-pen or hospitalization?	Yes	No
8	Have you ever fainted after receiving a vaccine?	Yes	No
9	Do you have a bleeding disorder or are taking a blood thinner (Aspirin, Warfarin, Coumadin, Eliquis, Xarelto etc)?	Yes	No
10	Are you taking immunosuppressive drugs or have a weaken immune system (eg: HIV infection, cancer, etc.)	Yes	No
11	Do you have dermal fillers?	Yes	No
12	Are you pregnant or breastfeeding?	Yes	No N/A
ONLY if this is your SECOND VACCINE- PLEASE Answer the questions BELOW :			
13	Are there any changes to the responses to questions 1 – 12?	Yes	No N/A
14	Did you experience <u>anaphylaxis</u> after a previous dose of the COVID-19 vaccine?	Yes	No N/A
15	Did you experience any of the following <u>within 4 hours</u> after receiving a previous dose of the COVID-19 vaccine: <i>anaphylaxis, hives, angioedema, or respiratory distress (eg: wheezing,)</i>	Yes	No N/A

Vaccine Consent Form

Print Name: _____ I have been given the FACT SHEET FOR RECIPIENTS AND CAREGIVERS understand the FDA has authorized the emergency use of the COVID-19 vaccine, which is not an FDA approved vaccine. I understand the benefits and risks of the vaccine. I understand that I may refuse vaccination. I have had the opportunity to ask questions about the vaccine and my questions have been answered to my satisfaction. I understand the known benefits and risks of the vaccine and understand that some risks may not be known. I authorize information about my vaccine administration and any vaccine reactions to be submitted to the Department of Health. I agree to stay onsite 15 minutes after receiving my vaccination. I understand that if I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, heirs, and my personal representatives, I hereby release the providers administering the vaccine and Medicap Pharmacy/Medicus Urgent Care/VNA Hospice and their owners, operators, directors, administrations, employees, and agents from any liability that may arise from this vaccine. **Under these terms, I consent to receive the required doses of Moderna or Pfizer COVID-19 Vaccine and to authorize the provider to bill my insurance for the immunization administration only:**

Sign here: _____ Date: _____

Parent cosign _____ Date: _____

Primary Insurance: _____ ID: _____ Group: _____ BIN: _____ PCN: _____

Provider USE Only Date of Administration: First Dose Second Dose _____

Moderna COVID-19 vaccine lot number: _____ Dose 0.5 ml Exp. date: _____ EUA Date 12/20/20

Pfizer COVID-19 vaccine lot number: _____ Dose 0.3 ml Exp. Date: _____ EUA Date 12/11/20

Intramuscular Injection Site: RD LD _____

Providers/Vaccinator Name: _____ Signature: _____

WAIVER AND RELEASE OF LIABILITY

IN CONSIDERATION OF the risk of injury that exists while participating in COVID VACCINE (hereinafter the "Activity"); and

IN CONSIDERATION OF my desire to participate in said Activity and being given the right to participate in same;

I HEREBY, for myself, my heirs, executors, administrators, assigns, or personal representatives (hereinafter collectively, "Releasor," "I" or "me", which terms shall also include Releasor's parents or guardian if Releasor is under 18 years of age), knowingly and voluntarily enter into this WAIVER AND RELEASE OF LIABILITY and hereby waive any and all rights, claims or causes of action of any kind arising out of my participation in the Activity; and

I HEREBY release and forever discharge CARBONDALE AREA SCHOOL DISTRICT, located at Rt 6- 101 Brooklyn St, Carbondale, Pennsylvania 18407, their affiliates, managers, members, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors and assigns (collectively "Releasees"), from any physical or psychological injury that I may suffer as a direct result of my participation in the aforementioned Activity.

I AM VOLUNTARILY PARTICIPATING IN THE AFOREMENTIONED ACTIVITY AND I AM PARTICIPATING IN THE ACTIVITY ENTIRELY AT MY OWN RISK. I AM AWARE OF THE RISKS ASSOCIATED WITH PARTICIPATING IN THIS ACTIVITY, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO: PHYSICAL OR PSYCHOLOGICAL INJURY, PAIN, SUFFERING, ILLNESS, DISFIGUREMENT, TEMPORARY OR PERMANENT DISABILITY (INCLUDING PARALYSIS), ECONOMIC OR EMOTIONAL LOSS, AND DEATH. I UNDERSTAND THAT THESE INJURIES OR OUTCOMES MAY ARISE FROM MY OWN OR OTHERS' NEGLIGENCE, CONDITIONS RELATED TO TRAVEL TO AND FROM THE ACTIVITY, OR FROM CONDITIONS AT THE ACTIVITY LOCATION(S). NONETHELESS, I ASSUME ALL RELATED RISKS, BOTH KNOWN AND UNKNOWN TO ME, OF MY PARTICIPATION IN THIS ACTIVITY.

I FURTHER AGREE to indemnify, defend and hold harmless the Releasees against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs.

I FURTHER ACKNOWLEDGE that Releasees are not responsible for errors, omissions, acts or failures to act of any party or entity conducting a specific event or activity on behalf of Releasees. In the event that I should require medical care or treatment, I authorize Carbondale Area School District to provide all emergency medical care deemed necessary, including but not limited to, first aid, CPR, the use of AEDs, emergency medical transport, and sharing of medical information with medical personnel. I further agree to assume all costs involved and agree to be financially responsible for any costs incurred as a result of such treatment. I am aware and understand that I should carry my own health insurance.

I FURTHER ACKNOWLEDGE that this Activity may involve a test of a person's physical and mental limits and may carry with it the potential for death, serious injury, and property loss. I agree not to participate in the Activity unless I am medically able and properly trained, and I agree to abide by the decision of the Carbondale Area School District official or agent, regarding my approval to participate in the Activity.

I HEREBY ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS "WAIVER AND RELEASE" AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY. I EXPRESSLY AGREE TO RELEASE AND DISCHARGE Carbondale Area School District AND ALL OF ITS AFFILIATES, MANAGERS, MEMBERS, AGENTS, ATTORNEYS, STAFF, VOLUNTEERS, HEIRS, REPRESENTATIVES, PREDECESSORS, SUCCESSORS AND ASSIGNS, FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION AND I AGREE TO VOLUNTARILY GIVE UP OR WAIVE ANY RIGHT THAT I OTHERWISE HAVE TO BRING A LEGAL ACTION AGAINST Carbondale Area School District FOR PERSONAL INJURY OR PROPERTY DAMAGE.

To the extent that statute or case law does not prohibit releases for ordinary negligence, this release is also for such negligence on the part of Carbondale Area School District, its agents, and employees.

I agree that this Release shall be governed for all purposes by Pennsylvania law, without regard to any conflict of law principles. This Release supersedes any and all previous oral or written promises or other agreements.

In the event that any damage to equipment or facilities occurs as a result of my or my family's or my agent's willful actions, neglect or recklessness, I acknowledge and agree to be held liable for any and all costs associated with any such actions of neglect or recklessness.

THIS WAIVER AND RELEASE OF LIABILITY SHALL REMAIN IN EFFECT FOR THE DURATION OF MY PARTICIPATION IN THE ACTIVITY, DURING THIS INITIAL AND ALL SUBSEQUENT EVENTS OF PARTICIPATION.

THIS AGREEMENT was entered into at arm's-length, without duress or coercion, and is to be interpreted as an agreement between two parties of equal bargaining strength. Both Participant, _____ and Carbondale Area School District agree that this agreement is clear and unambiguous as to its terms, and that no other evidence shall be used or admitted to alter or explain the terms of this agreement, but that it will be interpreted based on the language in accordance with the purposes for which it is entered into.

In the event that any provision contained within this Release of Liability shall be deemed to be severable or invalid, or if any term, condition, phrase or portion of this agreement shall be determined to be unlawful or otherwise unenforceable, the remainder of this agreement shall remain in full force and effect. If a court should find that any provision of this agreement to be invalid or unenforceable, but that by limiting said provision it would become valid and enforceable, then said provision shall be deemed to be written, construed and enforced as so limited.

In the event of an emergency, please contact the following person(s) in the order presented:

Emergency Contact

Contact Relationship

Contact Telephone

I, THE UNDERSIGNED PARTICIPANT, AFFIRM THAT I AM OF THE AGE OF 18 YEARS OR OLDER, AND THAT I AM FREELY SIGNING THIS AGREEMENT. I CERTIFY THAT I HAVE READ THIS AGREEMENT, THAT I FULLY UNDERSTAND ITS CONTENT AND THAT THIS RELEASE CANNOT BE MODIFIED ORALLY. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT AND THAT I AM SIGNING IT OF MY OWN FREE WILL.

Student's Name:

Student's Address:

Signature:

Date:

PARENT/GUARDIAN WAIVER

I HEREBY CERTIFY that I am the parent or guardian of _____
named above, and do hereby give my consent without reservation to the foregoing on
behalf of this individual.

MY CHILD IS IN COHORT A, B OR C (SELECT ONE)

I WOULD LIKE TO BE PRESENT FOR THE VACCINE ADMINISTRATION:
YES _____ **NO** _____

**IN THE EVENT THAT THE ABOVE IS NOT SELECTED OR THE PARENT IS NOT
PRESENT AT THE CHILD'S SCHEDULED VACCINE ADMINISTRATION, THE
VACCINE WILL BE ADMINISTERED WITHOUT THE PARENT PRESENT.**

Parent/Guardian Name: _____

Relationship to Minor: _____

Signature: _____

Date: _____