Rutowski Pharmacies

COVID-19 Vaccine Consent Form

Patient Info			
First Name	Last Name	Date of Birth	Age

Street Address	City	Zip Code	Phone

Screening Questions	Yes	No
Has it been at least 2 months since your last COVID vaccine?		
Have you had any vaccines in the last 14 days?		
Do you have any allergies to vaccines or vaccine components?		
Have you ever had a severe or immediate allergic reaction to a vaccine?		
Do you feel sick today?		
Do you have a fever today?		
Do you have a weakened immune system?		
Do you have a bleeding disorder or take a blood thinner?		
Do you have a history of myocarditis or pericarditis?		
Are you immunocompromised in any way?		

Consent

By signing below, I attest that I have received the COVID Vaccine Sheet (VIS) and have had the opportunity to ask questions. I understand the benefits and risks associated with receiving a vaccination. I request that the vaccine be administered to me, and it is recommended that I remain in the healthcare facility for 15 minutes after the vaccine. I authorize the pharmacy to notify my primary health care physician of the receipt.

☐ By checking this box, I authorize the pharmacy to upload my immunization to NYSIIS (NYS Vaccine database)

Signature	Date

Once you have completed this form, please present it with your insurance to the pharmacy.

Pharmacy Use				
Vaccine Name	Manufacturer	Lot	Exp Date	Site LD / RD

Administered By / Title	Signature	Date