Turenne PharMedCo
PHARMACY SERVICES

☐ RESIDENT
☐ LTC FACILITY STAFF
☐ OTHER _____

VACCINE ADMINISTRATION RECORD: INFORMED CONSENT

SECTION 1: INFORMATION ABOUT YOU (PLEASE PRINT)

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
DATE OF BIRTH:	GENDER (ASSIGNED AT BIRTH): ☐ MALE ☐ FEMALE	PHONE NUMBER (☐ PATIENT OR ☐ GUARDIAN):
RACE: ☐ Asian ☐ Native American / Alaskan ☐ Other Nonwhite ☐ White ☐ Black / African American ☐ Native Hawaiian / Other ☐ Pacific Islander ☐ Unknown		ETHNICITY: ☐ Hispanic / Latino ☐ Unknown ☐ Not Hispanic / Latino
LTC FACILITY NAME:	ADDRESS INSURANCE HAS ON FILE:	
CITY:	STATE:	ZIP CODE:
MEDICARE #:	PRIMARY INSURANCE (IF NOT MEDICARE):	MEDICAID #:
INSURANCE COMPANY:	PHONE #:	
INSURED'S NAME IF DIFFERENT THAN ABOVE:	RELATIONSHIP:	DATE OF BIRTH:

IS THIS THE PATIENT'S 1ST OR 2ND DOSE OF THE COVID-19 VACCINE? ☐ 1ST DOSE ☐ 2ND DOSE

SECTION 2: COVID SCREENING QUESTIONS (The following questions will help us determine your eligibility to be vaccinated today.)

Please check YES or NO for each question.	YES	NO
1. Are you feeling sick today?	☐	☐
2. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive?	☐	☐
3. Have you tested positive for and/or been diagnosed with COVID-19 infection within the past 10 days?	☐	☐
4. Have you had any COVID-19 antibody therapy within the last 90 days (e.g., Regeneron, Bamlanivimab, COVID Convalescent Plasma, etc.)?	☐	☐
5. Have you had any other vaccinations in the last 14 days (e.g., influenza vaccine, etc.)?	☐	☐
6. Have you had a severe allergic reaction (e.g., needed epinephrine or hospital care) to a previous dose of this vacinne or to any of the ingredients of this vaccine or any other vaccine or injectable therapy?	☐	☐
7. Do you carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, foods, vaccines or latex (e.g., eggs, bovine protein, gelatin, gentamicin, polymixin, neomycin, phenol, yeast or thimerosal)? If yes, please list:	☐	☐
8. Are you immunocompromised or on a medication that affects your immune system?	☐	☐
9. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?	☐	☐
10. Do you have any health conditions, such as heart disease, diabetes or asthma?	☐	☐
11. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillian-Barré syndrome (a condition that causes paralysis) or other nervous system problem?	☐	☐
12. Women: Are you pregnant or considering becoming pregnant in the next month?	☐	☐

I certify that I am (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to the Turenne PharMedCo, Inc., or its agents to administer the COVID-19 vaccine.

Patient/LTCF Representative: _____ Date: _____

I want to receive the following vaccination: COVID-19 VACCINATION

I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.

I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.

On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Turenne PharmedCo, Inc., and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.

I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Center for Disease Control and Prevention, or their respective designees as may be required by law, 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 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 applicable Provider: (a) the disclosure of my vaccination information by the applicable 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 applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and, to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies, 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 applicable 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 applicable 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 or federal law may permit certain disclosures of my vaccination information to or through the State HIE or to Government Agencies as required or permitted by law. I further authorize the applicable Provider to: (a) release my medical or other information, including any communicable disease (including HIV), and mental health information, to, or through, the State HIE or Government Agencies to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice. Turenne PharMedCo may disclose your vaccination information from this visit for public health purposes and will send this information to the Medical Director or Administrator of the LTCF identified above. If you are an employee of the LTCF, Turenne PharMedCo will send your vaccination information to your employer as required.

Print Name: _____ Patient/Authorized Signature: _____ Date: _____

HEALTHCARE PROVIDER ONLY

SECTION 3	INITIAL
1. I have reviewed the Patient Information and Screening Questions.	
2. I have verified that this is the vaccine requested by the patient.	
3. This vaccine is appropriate for this patient based on the Age Guidelines and Other Guidelines provided by federal and/or state regulations and company policies.	
3a. Does this patient have a high-risk medical condition? If "YES", list here:	☐ YES ☐ NO
4. I confirm(ed) the patient's Name, DOB and Requested Vaccine, and verified it matches the information on the VAR form.	
5. I have reviewed the Screening Questions and answers.	
6. I provided an EUA Fact Sheet to the patient or the LTCF representative. EUA Fact Sheet Date: Date given to patient:	

SECTION 4: Complete AFTER vaccine administration

VACCINE	MANUFACTURER	NDC	LOT #	EXP. DATE	DOSE	SITE OF ADMINISTRATION	DOSAGE
					☐ SINGLE DOSE ☐ DOSE 1 OF 2 ☐ DOSE 2 OF 2		

Clinician's Name (Print): _____ Title: _____

Clinician's Signature: _____ Administration Date: _____