Ready Meds Pharmacy
Renton • Spokane • Lacey • Everett

1412 SW 43RD STREET · Suite 120 · Renton, WA 98057
·Phone (877) 425-MEDS (6337) www.readymedspharmacy.com
·Fax (877) 509-MEDS (6337) newadmit@readymedspharmacy.com

Adult Family Home COVID-19 Vaccine – Enrollment Cover Sheet

If you are interested in Ready Meds Pharmacy administering COVID-19 vaccine at your facility, please return this letter with the attached informed consent forms completed for each client via fax. Please keep all documentation together. Sending them separately can delay processing time.

_____
Name of Facility

_____
Address

_____
Address

_____
Contact Name

_____
Phone Number

_____
Number of Individuals to be Vaccinated

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COVID-19 Vaccination

☐ **Primary Series**

☐ **Booster #1** ☐ **Booster #2**
Must Fill Out #2 On Questionaire For Either Booster

Insurance Information

☐ Medicare#_____Other Insurance (provide copy of card)
☐ Unisured Please Provide Copy of State ID and/or Driver's License
_____

Name:_____ Race:_____ Sex: ☐ M ☐ F

Allergies:_____DOB:_____ Phone #:_____

Address:_____Date:_____

The following questions will help us determine which vaccines you may be given today. If you answer "YES" to any questions, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

		YES	NO	DON'T KNOW
1.	Are you feeling sick today?	☐	☐	☐
2.	Have you ever recieved a dose of COVID-19 vaccine? • If yes, record which vaccine and when did you received? ☐Pfizer 1st___2nd____Booster____ ☐Moderna 1st_____ 2nd_____Booster____ ☐ J+J 1st_____ Booster_____	☐	☐	☐
3.	Have you ever had an allergic reaction to any component of the COVID-19 vaccine, including polyethylene glycol	☐	☐	☐
4.	Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
5.	Do you have a weakened immune system caused by something such as HIV infection or	☐	☐	☐
6.	Cancer or do you take immunosuppresive drugs or therapies?	☐	☐	☐
7.	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication?	☐	☐	☐
8.	For women: Are you pregnant or breastfeeding	☐	☐	☐
9.	Have you received any vaccinations in the past 14 days?	☐	☐	☐
	COVID-19 Screening questionnaire for immunization			
1.	Do you currently or have you in the past 14 days, experienced the new onset of 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?	☐	☐	☐
2.	In the past 14 days, have you had contact with someone who tested positive for COVID-19?	☐	☐	☐

Please read the following statements and sign below on the signature line.
I have read or have had explained the information provided about the vaccine I am about to receive. I have received and read a vaccine information statement. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of vaccination and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. Medicare, I do hereby authorize Ready Meds Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

X_____ Date:
Signature of person to receive vaccine or person authorized to make request (parent or guardian)

For office use only

Vaccine: 1st Dose COVID-19	Vaccine: 2nd Dose COVID-19	Other
Lot: #	Lot: #	Lot: #
Mfr.	Mfr.	Mfr.
Date on VIS	Date on VIS	Date on VIS
Site	Site	Site
Date given	Date given	Date given

X_____ Date:_____
Signature of Administrator