COSTCO PHARMACY

Attestation Form for Booster Dose Eligibility

At this time, COVID vaccine booster doses are authorized by the FDA & CDC for the following individuals:

- Received 2 doses of Pfizer vaccine and the 2nd dose was at least 6 months ago AND
  - Age 65 or over
  - Age 18 or over and resident of long-term care setting
  - Age 18-64 with certain underlying medical conditions. Medical conditions include:
    - Cancer
    - Chronic kidney disease
    - Chronic lung disease
    - Dementia or other neurological conditions
    - Diabetes
    - Down syndrome
    - Heart conditions
    - HIV infection
    - Immunocompromised
    - Liver disease
    - Overweight and obesity
    - Pregnancy
    - Sickle cell disease or thalassemia
    - Smoking, current or former
    - Solid organ or blood stem cell transplant recipient
    - Stroke or cerebrovascular disease
    - Substance use disorder
  - Age 18-64 at increased risk for COVID-19 exposure and transmission due to occupational or institutional setting
- Received 2 doses of Pfizer or Moderna vaccine and the 2nd dose was at least 28 days ago AND
  - Moderately to severely immunocompromised

Individuals must self-attest that they meet these criteria to be eligible for a COVID vaccine booster dose.

Patient name:_____ Date of birth:_____

Prior vaccine received:_____ Date of last dose:_____

Check the box applicable to you:
□ Yes, I meet the criteria.
□ No, I do not meet the criteria.

COVID-19 Immunization Consent Form

COSTCO WHOLESALE

PATIENT INFORMATION

PATIENT'S LAST NAME | PATIENT'S FIRST NAME | MI | GENDER (M/F) | BIRTH DATE (MM/DD/YYYY)

ADDRESS | CITY | STATE | ZIP

10-DIGIT PHONE NUMBER | COUNTY (WHERE PATIENT LIVES) | PRIMARY CARE PROVIDER (MD, DO, NP, PA) | PROVIDER PHONE/FAX

PRIMARY CARE PROVIDER ADDRESS

RACE - Check all that apply ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Other race

ETHNICITY - Check one ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Do you have any of the following? - Check all that apply ☐ Asthma ☐ Serious Heart Condition ☐ Liver Disease ☐ Chronic Lung Disease ☐ Chronic Kidney Disease ☐ Diabetes ☐ Severe Obesity ☐ Immunocompromised

INSURANCE INFORMATION

☐	☐	☒ Anthem Blue Cross/Navitus	SISC	610602	
UNINSURED - STATE ID	MEDICARE #	OTHER INSURANCE - CARRIER NAME	GROUP #	BIN	ID #

☐ PRIMARY BENEFICIARY/CARDHOLDER ☐ DEPENDENT

COVID VACCINE INFORMATION

Have you received a vaccine for COVID in the past? ☐ Yes ☐ No

If yes: Which vaccine did you receive? _____ Where did you receive your vaccine? _____ How many doses did you receive? _____

PRECAUTIONS AND CONTRAINDICATIONS (Please check yes or no for each question)

1. Are you sick today? ☐ Yes ☐ No
2. Do you have allergies to medications, food or vaccines? ☐ Yes ☐ No
   Allergies _____
3. Have you ever had a serious reaction after receiving an immunization? ☐ Yes ☐ No
4. Have you ever fainted or felt dizzy after receiving an immunization? ☐ Yes ☐ No
5. Are you currently being treated for a long-term health problem such as heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder? ☐ Yes ☐ No
6. Are you currently being treated for cancer, leukemia, AIDS or any other immune system problem? ☐ Yes ☐ No
7. Are you currently taking cortisone, prednisone, other steroids or anti-cancer drugs, or have you had X-ray treatments? ☐ Yes ☐ No
8. Do you have a history of Guillain-Barre Syndrome? ☐ Yes ☐ No
9. Have you had a seizure, brain or nerve problem? ☐ Yes ☐ No
10. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? ☐ Yes ☐ No
11. For women: Are you pregnant or is there a chance you could become pregnant during the next month? ☐ Yes ☐ No
12. Have you received any vaccinations in the past 4 weeks? ☐ Yes ☐ No
    If yes, what vaccines? _____
13. Are you allergic to eggs? ☐ Yes ☐ No
14. Are you allergic to latex? ☐ Yes ☐ No

ADVERSE REACTIONS

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of any vaccine causing serious harm, or death, is extremely small. Local symptoms may include: slight tenderness, redness, itching or swelling at the site of injection.

Systemic symptoms may include: fever, malaise and muscle pain. Other systemic symptoms may occur infrequently. These reactions usually begin 6 to 12 hours after immunization and can persist for a few days. Immediate presumable allergic reactions such as hives, angioedema, allergic asthma or systemic anaphylaxis occur rarely after immunization. These reactions may result from hypersensitive reactions in people with severe egg allergy, and such people should not be given certain vaccines that contain eggs. People with documented immunoglobulin E (IgE)-mediated hypersensitivities to eggs or any other vaccine components, including thimerosal, may also be at increased risk of reactions from immunizations.

In the case of a severe reaction such as a high fever, behavior changes or flu-like symptoms that occur after vaccination, see a doctor right away. Signs of an allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, or dizziness within a few minutes to a few hours after the shot.

I have read the adverse reactions associated with the administration of vaccines. The vaccine you are receiving may have been authorized by the FDA under Emergency Use Authorization (EUA). Vaccines authorized under EUA have been rigorously assessed for efficacy and safety. A copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization(s) or the receipt of the immunization(s) by the person named below for whom I am the legal guardian ('Ward'). My medical record may be shared with my physician or other healthcare provider and the medical record of my Ward may be shared with his/her physician or other healthcare provider. I am requesting that the immunization(s) be given to me or my Ward. I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives and assigns, hereby release Costco, and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt by my Ward of this or these immunization(s). Neither Costco nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. Costco will use and disclose your personal and health information or the personal and health information of your Ward, to treat you or your Ward, to receive payment of the care we provide, and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to you and your Ward's personal health information. I acknowledge that I have received a copy of the Notice of Privacy Practices.

SIGNATURE/LEGAL GUARDIAN | PRINT NAME

ADMINISTRATIVE RECORD For pharmacy use only

DATE OF VACCINATION/DATE VIS GIVEN | PHARMACIST/PRESCRIBER SIGNATURE | PHARMACY NAME | PHARMACY ADDRESS

VACCINE: _____ SITE OF INJ.: _____ LOT NO.: _____ EXP. DATE: _____

RT OF ADMIN: _____ MFR: _____ VIS VERSION: _____ DOSAGE: _____

Please provide a copy of this form to your physician and/or healthcare provider for your permanent medical records.

WHITE – Administrative Copy **YELLOW** – Patient Copy