

## COVID-19 Immunization Screening and Consent Form

RECIPIENT INFORMATION			
Patient's last name:	First:	M.I.	Sex <input type="checkbox"/> M <input type="checkbox"/> Other <input type="checkbox"/> F
Date of Birth (MM/DD/YY)			
Street address:		City, State:	Zip Code:
Phone:		Email:	

ETHNICITY	
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Unknown
<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Declined

RACE	
<input type="checkbox"/> Native American or Alaskan	<input type="checkbox"/> Native Hawaiian or Pacific Islander
<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> African American or Black	<input type="checkbox"/> Other
	<input type="checkbox"/> Declined

<input type="checkbox"/> I DO NOT HAVE INSURANCE	INSURANCE INFORMATION
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*If you have insurance please provide your information. We are able to get reimbursed by insurance companies for administering the vaccine in order to fund our clinic. **There will be no cost to you.** If you do not have insurance you will still be able to get the vaccine.*

Insurance Carrier:	Member ID:	
Subscriber's Name:	Birth Date of Subscriber:	Group No:
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.

**If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may 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 received a dose of COVID-19 vaccine?			
• If <b>yes</b> , which vaccine product did you receive?      # of doses _____ <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Another product _____			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• Any vaccine?			
• Any drug/medicine?			
• Anything else? (Please specify)			

**Yes      No      Don't know**

4. Have you received any vaccine in the last 14 days?			
5. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
6. Have you received antibody therapy as treatment for COVID-19?			
7. Do you have a weakened immune system or take immunosuppressive drugs?			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			

**Emergency Use Authorization**

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not undergone the same type of review as an FDA-approved or cleared product. However, the FDA’s decision to make the vaccine available is based on the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

**Consent**

I have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if my vaccine requires two doses, I will need to be administered (given) two doses of this vaccine in order for it to be effective. I have had a chance to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health plan, Medicare or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

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Recipient/Surrogate/Guardian Signature      Date/Time      Print Name      Relationship to patient, if other than recipient

Area Below to be Completed by Vaccinator				
<b>Which vaccine is the patient receiving today?</b>				Vaccinator Initials _____
Vaccine Name	Administration		EUA Fact Sheet Date	Lot Number
Pfizer/ BioNTech	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose	1/25/21	
Pfizer/ BioNTech	<input type="checkbox"/> Third Dose	<input type="checkbox"/> Fourth Dose		

Administration Site       Left Deltoid       Right Deltoid