Seattle Infectious Disease Clinic
509 Olive Way Suite 752, Seattle, WA 98101-1773
(206) 682-3444 | Fax: (206) 682-3555 | SeattleIDC.com

COVID-19 Immunization Screening and Consent Form

RECIPIENT INFORMATION

Patient's last name: First: M.I.	Sex ❑ M ❑ F ❑ Trans MTF ❑ Trans FTM ❑ Other	Date of Birth (MM/DD/YY)
Street address:	City, State:	Zip Code:
Phone:	Email:	

ETHNICITY

❑ Hispanic ❑ Unknown
❑ Non-Hispanic ❑ Declined

RACE

❑ Native American or Alaskan
❑ Asian
❑ African American or Black
❑ Native Hawaiian or Pacific Islander
❑ White
❑ Other
❑ Declined

INSURANCE INFORMATION

___ I DO NOT HAVE INSURANCE

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: ❑ Self ❑ Spouse ❑ Child ❑ 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 **yes**, which vaccine product did you receive? # of doses _____ ☐ Pfizer ☐ Moderna ☐ 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. Do you have a bleeding disorder or are you taking a blood thinner?			
5. Are you pregnant or breastfeeding?			

CONSENT FOR VACCINATION

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.

_____

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

Area Below to be Completed by Vaccinator				
Which vaccine is the patient receiving today?				Vaccinator Initials _____
Vaccine Name	Administration		VIS Date	Lot Number
Pfizer/ BioNTech	□ First Dose	□ Second Dose	1/3/2022	
	□ Third Dose	□ Fourth Dose		

Administration Site □ Left Deltoid □ Right Deltoid