COVID-19 IMMUNIZATION SCREENING AND CONSENT FORM -PLEASE PRINT CLEARLY-

Recipient Name:	**DOB:**	**Gender:**
Address:	**City/State:**	**Zip:**
Parent/Guardian (if applicable):	**Email:**	**Phone#**
Primary Insurance Name:	**Primary Insurance ID#:**	**Group #:**
IF OVER 65, Please Provide Medicare B ID# (Red,White & Blue Card):	**Primary Dr. Name:**	**Phone #:**

-SELECT WHICH DOSE YOU ARE RECEIVING TODAY-

☐ **MODERNA** **NAME AND DATE OF LAST DOSE IF APPLICABLE:**_____	☐ **FIRST DOSE** ☐ **SECOND DOSE** ☐ **BOOSTER DOSE**
☐ **PFIZER** **NAME AND DATE OF LAST DOSE IF APPLICABLE:**_____	☐ **FIRST DOSE** ☐ **SECOND DOSE** ☐ **BOOSTER DOSE**
☐ **JANSSEN (J&J)** **NAME AND DATE OF LAST DOSE IF APPLICABLE:**_____	☐ **FIRST DOSE** ☐ **BOOSTER DOSE**

-SCREENING QUESTIONNAIRE-

	QUESTIONS (Please Read Carefully and Answer Truthfully)	YES	NO	UNKNOWN
1.	Are you feeling sick today?			
2.	In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a health care provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?			
3.	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? *If yes, when did you receive the last dose?* Date: _____			
4.	Have you ever had an immediate allergic reaction (e.g. hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injection, or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything?			
5.	Are you pregnant or considering becoming pregnant?			
6.	Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?			
7.	Do you take any medications that affect your immune system,such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?			

***QUESTIONS CONTINUED ON BACK OF PAGE AND THEN SIGN AND DATE →

8.	Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?			
9.	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?			
10.	If you had a previous dose of Janssen (Johnson & Johnson), did you develop thrombosis with thrombocytopenia syndrome (TTS)?			

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. Please note: FDA approved the Pfizer-BioNTech COVID-19 vaccine as a two-dose series in individuals 16 years of age and older. The vaccine continues to be available under an EUA for certain populations, including for those individuals 12 through 15 years of age and for the administration of a third dose in the populations set forth in the consent section below.

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 to be considered fully vaccinated. Further, I understand that a booster dose of COVID-19 vaccine may be recommended at least 2 months following the first dose of Janssen vaccine or at least 6 months following the second dose of PfizerBioNTech or Moderna COVID-19 vaccine if I am a member of a certain population (e.g., 65 years or older, 18 years old or older and a resident of a long term care facility, 50-64 years with an underlying medical condition, 18-49 years old with an underlying medical condition based on individual benefits and risks, 18-64 years old and at an increased risk for COVID-19 exposure and transmission because of working or living in a high-risk setting and based on individual benefits and risks) to increase my protection.

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.

X_____

Recipient/Guardian Signature **Date** **Relationship to Patient (if other than recipient)**

-AREA BELOW TO BE FILLED OUT BY VACCINATOR-

VACCINE NAME	ADMINISTRATION	DOSAGE	ADMINISTRATION SITE:	LOT # / EXPIRATION:
Pfizer/BioNTech	☐ First Dose ☐ Second Dose ☐ Booster Dose	☐ 0.3 ml	☐ Left Deltoid ☐ Right Deltoid	
Moderna	☐ First Dose ☐ Second Dose ☐ Booster Dose	☐ 0.5 ml ☐ 0.25 ml	☐ Left Deltoid ☐ Right Deltoid	
Janssen	☐ First Dose ☐ Booster Dose	☐ 0.5 ml	☐ Left Deltoid ☐ Right Deltoid	

□ I have provided the patient (and/or parent, guardian or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained.

VACCINATOR NAME (PRINT) **SIGNATURE** **DATE**