Coastal Care Partners
Customer-Focused Healthcare

COVID-19 Bivalent Booster Vaccine

INFORMATION AND CONSENT FORM

NAME (Last) (First)	Date of Birth: _____/_____/_____	**Age:**
ADDRESS	**EMAIL:**	
CITY **STATE** **ZIP**	**DAYTIME PHONE NUMBER**	
EMERGENCY CONTACT: (Name) (Relation) (Phone Number)		

Race: (check only 1) ____ Asian/Polynesian _____ Black _____ White ____Multiracial ____ Native Am/Alaskan _____ Unknown	**Ethnicity: (check only 1)** _____ Not Hispanic _____ Hispanic _____ Unknown	**Language:** ____ English ____ Other:	**Gender:** _____ Male _____ Female

Please answer the health questions below:	**Yes**	**No**	**Do Not Know**
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine? *If yes, which vaccine product: Pfizer ☐ Moderna ☐ Janssen ☐ Other ☐			
3. Have you ever had a severe allergic reaction that required treatment with Epinephrine or EpiPen, or caused you to go to the hospital, caused hives, swelling, or respiratory distress including wheezing?			
*Was the severe reaction after receiving a COVID-19 vaccine?			
*Was the severe reaction after receiving another vaccine or another injectable medication?			

4. Check all that apply to you:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Guillain-Barre Syndrome
- ☐ Have a bleeding disorder or take blood thinners
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (i.e., HIV infection, cancer). If yes, list condition: _____
- ☐ Take immunosuppressive drugs or therapies. If yes, please list: _____
- ☐ 18-64 with underlying chronic health condition(s): If yes, please list: _____
- ☐ Resident of long-term care facility (nursing home, senior living facility, assisted living)
- ☐ At high risk of occupational/institutional exposure to COVID-19

I have been given a copy and have read the Emergency Use Authorization (EUA) and reviewed the FDA Fact Sheet for Recipients and Caregivers for the COVID-19 bivalent booster vaccine product I will be administered (choose one of the following):
_____ Pfizer Bivalent Booster (age 12 & over); _____ Moderna Bivalent Booster (age 18 and over)
I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine indicated and ask that it be given to me, or the person named for whom I am authorized to make this request.
My signature acknowledges that I was advised to remain on site for 15 minutes after receiving the vaccine. Those with previous anaphylactic reactions should stay for 30 minutes

_____ _____ _____
Date **Print Name** **Patient or Parent/Guardian Signature**

FOR ADMINISTRATIVE USE ONLY

Vaccine recipient provided:
Pfizer Bivalent Booster
Moderna Bivalent Booster
Other vaccine information statement(s)_____

Date Administered	Dose	Route	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
	_____mL 1st COVID-19 Bivalent Booster _____ml 2nd COVID-19 Bivalent Booster	☐ IM - L Arm ☐ IM - R Arm ☐ Other: _____	____ Pfizer ____ Moderna			