COVID-19 Immunization Screening and Consent Form

Clinic Name: ____________________________________ Date________________

Name (please print):				Date of Birth:		Sex: M F
Marital Status: S – Single D – Divorced M –Married W-Widowed SEPARATED – Legally separated		Ethnicity: ☐ Hispanic origin ☐ Non-Hispanic origin			Race: ☐ Black or African American ☐ White ☐ Native American or Alaskan ☐ Other/multiracial ☐ Decline	
Address:	City:		State:	Zip:		County:
Phone:	Email Address:					
Primary Care Physician:						
Parent/Guardian (if applicable):						

Occupation Data Checklist for COVID-19 Vaccine Recipients: Please **check only one** box in the section below. Please select the primary reason you are receiving the COVID-19 vaccine.

PHASE 1A		☐	State of Ohio Dept. of Rehabilitation & Correction – LTC Residents
☐	Assisted Living Facility – Resident	☐	Congregate Care Facility – Resident
☐	Assisted Living Facility – Staff	☐	Congregate Care Facility – Staff
☐	Skilled Nursing Facility (RCF) – Resident	☐	Hospital Worker – Clinical Staff
☐	Skilled Nursing Facility (RCF) – Staff	☐	Hospital Worker – Administrative Staff
☐	State of Ohio Dept. of Dev. Disabilities (DODD) - Resident	☐	Hospital Worker – Ancillary Staff
☐	State of Ohio Dept. of Dev. Disabilities (DODD) - Staff	☐	Non-Hospital healthcare worker – Administrative Staff
☐	State of Ohio Veterans Home - Resident	☐	Non-Hospital healthcare worker – Ancillary Staff
☐	State of Ohio Veterans Home - Staff	☐	Non-Hospital healthcare worker – Clinical Staff
☐	State of Ohio Mental Health and Addiction Services (MHAS) - Resident	☐	Emergency Medical Services (EMTs/Paramedics)
☐	State of Ohio Mental Health and Addiction Services (MHAS) - Staff	☐	State of Ohio Dept. of Rehabilitation & Correction – LTC Staff
PHASE 1B			
☐	Individuals over 80 years of age	☐	Individuals with congenital disorders or early onset conditions
☐	Individuals age 75 to 79 years of age	☐	Individuals working in K-12 schools
☐	Individuals age 70 to 74 years of age		
☐	Individuals age 65 to 69 years of age	☐	Other

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Name ____________________________________

Screening Questionnaire			
	Yes	**No**	**Unknown**
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 ? ☐ Pfizer ☐ Moderna ☐ Another product ____________________________________			
3. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? *If yes, when did you receive the last dose?*__________________________	☐	☐	☐
5. 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.)			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
• Polysorbate	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
6. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (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.)	☐	☐	☐
7. Have you ever had an allergic reaction to another vaccine (e.g. anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	☐	☐	☐
8. Have you had any vaccines in the past 14 days (2 weeks) including flu shot? *If yes, how long ago was your most recent vaccine?* _______________________	☐	☐	☐
9. Are you pregnant, considering being pregnant, or breastfeeding?	☐	☐	☐
10. Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	☐	☐	☐
11. 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?	☐	☐	☐
12. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐

Name ___________________________________

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 completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Recipient Signature: ____ Date: ________________

Relationship to patient, if other than recipient ____

Consent for Vaccination and Administrative Billing

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that this vaccine requires two doses, which need to be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction. 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). 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 insurance plan, Medicare, Medicaid 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. I authorize payment be made directly to ACPH for medical services provided to me or my family members. I authorize the release of any medical or other information necessary to process this claim.

Recipient Signature: ____ Date: ________________

Relationship to patient, if other than recipient ____

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Area Below to be Completed by the Vaccinator

Vaccine Name	Administration		Dosage/Route/Site			Lot Number/ Expiration date		EUA Fact Sheet Date
Pfizer/ BioNTech	□ 1st Dose	□ 2nd Dose	.5ml	IM	LD RD			
Moderna (circled)	□ 1st Dose	□ 2nd Dose	.5ml	IM	LD RD			12/18/20
Astra-Zeneca	□ 1st Dose	□ 2nd Dose	.5ml	IM	LD RD			
Janssen	□ 1st Dose	□ 2nd Dose	.5ml	IM	LD RD			

□ I have reviewed side effects with patient (and parent/guardian, as applicable)
□ I confirm that the patient was given an opportunity to ask questions about the vaccination, and all the questions asked by them have been answered correctly and the best of my ability.

Vaccinator Signature ____Date_________________

Insurance Information:

Primary Insurance	
Name of Insurance:	Policy Holder's Name:
Relationship to Patient:	ID # Group #:
Policy Holder's Phone #:	Policy Holder's Date of Birth:
Secondary Insurance (*)	
Name of Insurance:	Policy Holder's Name:
Relationship to Patient:	ID # Group #:
Policy Holder's Phone #:	Policy Holder's Date of Birth:

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