

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: <input type="checkbox"/> Hispanic origin <input type="checkbox"/> Non-Hispanic origin | | Race: <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native American or Alaskan <input type="checkbox"/> Other/multiracial <input type="checkbox"/> 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. See next page for more

| | | | |
|--------------------------|--|--------------------------|--|
| PHASE 1A | | <input type="checkbox"/> | State of Ohio Dept. of Rehabilitation & Correction – LTC Residents |
| <input type="checkbox"/> | Assisted Living Facility – Resident | <input type="checkbox"/> | State of Ohio DRC – LTC Staff |
| <input type="checkbox"/> | Assisted Living Facility – Staff | <input type="checkbox"/> | Congregate Care Facility – Resident |
| <input type="checkbox"/> | Skilled Nursing Facility (RCF) – Resident | <input type="checkbox"/> | Congregate Care Facility – Staff |
| <input type="checkbox"/> | Skilled Nursing Facility (RCF) – Staff | <input type="checkbox"/> | Hospital Worker – Clinical Staff |
| <input type="checkbox"/> | State of Ohio Dept. of Dev. Disabilities (DoDD) – Resident | <input type="checkbox"/> | Hospital Worker – Administrative Staff |
| <input type="checkbox"/> | State of Ohio Dept. of Dev. Disabilities (DoDD) - Staff | <input type="checkbox"/> | Hospital Worker – Ancillary Staff |
| <input type="checkbox"/> | State of Ohio Veterans Home – Resident | <input type="checkbox"/> | Non-Hospital healthcare worker – Administrative Staff |
| <input type="checkbox"/> | State of Ohio Veterans Home – Staff | <input type="checkbox"/> | Non-Hospital healthcare worker – Ancillary Staff |
| <input type="checkbox"/> | State of Ohio Mental Health and Addiction Services (MHAS) – Resident | <input type="checkbox"/> | Non-Hospital healthcare worker – Clinical Staff |
| <input type="checkbox"/> | State of Ohio Mental Health and Addiction Services (MHAS) – Staff | <input type="checkbox"/> | Emergency Medical Services (EMTs/Paramedics) |
| PHASE 1B | | | |
| <input type="checkbox"/> | Individuals over 80 years of age | <input type="checkbox"/> | Individuals and congenital disorders or early onset conditions with IDD |
| <input type="checkbox"/> | Individuals age 75 to 79 years of age | <input type="checkbox"/> | Individuals working in K-12 schools |
| <input type="checkbox"/> | Individuals age 70 to 74 years of age | <input type="checkbox"/> | Individuals and congenital disorders or early in life conditions that carried into adulthood without IDD |
| <input type="checkbox"/> | Individuals age 65 to 69 years of age | | |
| PHASE 1C | | | |
| <input type="checkbox"/> | Diabetes Type 1 | <input type="checkbox"/> | Pregnant |
| <input type="checkbox"/> | Bone Marrow Transplant Recipient | <input type="checkbox"/> | ALS |
| <input type="checkbox"/> | Childcare Services Worker | <input type="checkbox"/> | Funeral Services Worker |
| <input type="checkbox"/> | Law Enforcement, Corrections, Firefighter | | |

| | | | |
|--------------------------|---------------------------------------|--------------------------|------------------------------------|
| PHASE 1D | | | |
| <input type="checkbox"/> | Diabetes Type 2 | <input type="checkbox"/> | End Stage Renal Disease |
| PHASE 1E | | | |
| <input type="checkbox"/> | Cancer | <input type="checkbox"/> | Chronic Kidney Disease |
| <input type="checkbox"/> | Chronic Obstructive Pulmonary Disease | <input type="checkbox"/> | Heart Disease |
| <input type="checkbox"/> | Obesity | | |
| PHASE 2A | | PHASE 2B | |
| <input type="checkbox"/> | Individuals age 60 to 64 years of age | <input type="checkbox"/> | Individuals age 50-59 years of age |
| PHASE 2C | | PHASE 2D | |
| <input type="checkbox"/> | Individuals age 40-49 years of age | <input type="checkbox"/> | Individuals age 16-39 years of age |

| Screening Questionnaire | | | |
|--|--------------------------|--------------------------|--------------------------|
| | Yes | No | Unknown |
| 1. Are you feeling sick today? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Have you been tested for COVID within the last seven days? | <input type="checkbox"/> | <input type="checkbox"/> | |
| • If yes, is your COVID test result pending at this time? | <input type="checkbox"/> | <input type="checkbox"/> | |
| • If yes and you have received your result, what was your result? (check one below) | | | |
| <input type="checkbox"/> Positive | | | |
| <input type="checkbox"/> Negative | | | |
| 3. Have you ever received a dose of COVID-19 vaccine? | <input type="checkbox"/> | <input type="checkbox"/> | |
| • If yes, which vaccine product did you receive? | | | |
| <input type="checkbox"/> Pfizer | | | |
| <input type="checkbox"/> Moderna | | | |
| <input type="checkbox"/> Another product _____ | | | |
| 4. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? <i>If yes, when did you receive the last dose?</i> _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. 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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Polysorbate | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • A previous dose of COVID-19 vaccine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. 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.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | |
|---|--------------------------|--------------------------|--------------------------|
| 8. 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. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you had any vaccines in the past 14 days (2 weeks) including flu shot? <i>If yes, how long ago was your most recent vaccine?</i> _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are you pregnant, considering being pregnant, or breastfeeding? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have a bleeding disorder or are you taking a blood thinner? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you have dermal fillers? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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 _____

Name _____

Area Below to be Completed by the Vaccinator

| Vaccine Name | Administration | | Dosage/Route/Site | | | Lot Number/ Expiration date | | EUA Fact Sheet Date |
|-----------------------------|-----------------------------------|-----------------------------------|-------------------|----|-------|-----------------------------|--|---------------------|
| | <input type="checkbox"/> 1st Dose | <input type="checkbox"/> 2nd Dose | .5ml | IM | LD RD | | | |
| Pfizer/ BioNTech | <input type="checkbox"/> | <input type="checkbox"/> | .5ml | IM | LD RD | | | |
| Moderna | <input type="checkbox"/> | <input type="checkbox"/> | .5ml | IM | LD RD | | | 12/18/2020 |
| Astra-Zeneca | <input type="checkbox"/> | <input type="checkbox"/> | .5ml | IM | LD RD | | | |
| Janssen (Johnson & Johnson) | <input type="checkbox"/> | <input type="checkbox"/> | .5ml | IM | LD RD | | | 2/27/2021 |

- 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: |