

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):					

Please check if this applies:			
<input type="checkbox"/>	One Dose	<input type="checkbox"/>	Third Dose (immune compromised)
<input type="checkbox"/>	Second Dose	<input type="checkbox"/>	Booster Dose

Screening Questionnaire		
	Yes	No
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product did you use? <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Novavax	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you had any type of vaccination in the last two weeks?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to: <ul style="list-style-type: none"> something other than a component of COVID-19 vaccine polyethylene glycol (PEG) polysorbate a previous dose of COVID-19 vaccine a vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies. 	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had an allergic reaction to another vaccine or any injection in the past? (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"/>
6. Have you been identified as either a probable or confirmed case of COVID-19 in the last two weeks?	<input type="checkbox"/>	<input type="checkbox"/>

7. Have you ever tested positive for COVID-19 or has a doctor ever told you that had had COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you received antibody therapy (monoclonal or convalescent plasma) as treatment for COVID-19 in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have any serious health conditions (often called co-morbidities)?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have a weakened immune system (i.e., from HIV or cancer) or are you on immunosuppressive drugs?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have a history of or a risk factor for a blood clotting disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13. Are you pregnant or breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have dermal fillers?	<input type="checkbox"/>	<input type="checkbox"/>
15. Check all that apply to you: <input type="checkbox"/> Am a female between ages 18 and 49 years old <input type="checkbox"/> Am a male between ages 12 and 29 years old <input type="checkbox"/> Have a history of myocarditis or pericarditis <input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 Infection <input type="checkbox"/> Have a history of heparin-induced thrombocytopenia <input type="checkbox"/> History of Guillian-Barré Syndrome (GBS)		

Emergency Use Authorization

The FDA has made the COVID-19 vaccine for the Pfizer, Moderna, Johnson & Johnson, and Novavax 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 _____

6/17/2022 - For the Pfizer-BioNTech COVID-19 Vaccine, the FDA amended the EUA to include use of the vaccine in individuals 6 months through 4 years of age. The vaccine had been authorized for use in individuals 5 years of age and older. 6/17/2022 - For the Moderna COVID-19 Vaccine, the FDA amended the emergency use authorization (EUA) to include use of the vaccine in individuals 6 months through 17 years of age. The vaccine had been authorized for use in adults 18 years of age and older.

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 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		Fact Sheet/ EUA Fact Sheet Date
Comirnaty Pfizer/ BioNTech	<input type="checkbox"/> 1st Dose	<input type="checkbox"/> 2nd Dose	<input type="checkbox"/> 3rd Dose <input type="checkbox"/> Booster Dose	.3ml	IM	LD RD			6/17/2022
Moderna (Red cap/blue border)	<input type="checkbox"/> 1st Dose	<input type="checkbox"/> 2nd Dose	<input type="checkbox"/> 3rd Dose <input type="checkbox"/> Booster Dose	.5ml .25ml	IM	LD RD			6/17/2022
Moderna <u>Booster Dose</u> (Dark blue cap/purple border)	<input type="checkbox"/> Booster Dose			.5 ml	IM	LD RD			6/17/2022
Janssen (Johnson & Johnson)	<input type="checkbox"/> 1st Dose	<input type="checkbox"/> Booster Dose		.5ml	IM	LD RD			5/5/2022
Novavax	<input type="checkbox"/> 1st Dose	<input type="checkbox"/> 2nd Dose		.5ml	IM	LD RD			7/13/2022

☐ 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: