ALLEN COUNTY PUBLIC HEALTH
Allen County Combined Health District

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):				

Please check if this applies:			
☐	One Dose	☐	Third Dose (immune compromised)
☐	Second Dose	☐	Booster Dose

Screening Questionnaire	Yes	No
1. Are you feeling sick today?	☐	☐
2. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product did you use? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Novavax	☐	☐
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to: • 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.	☐	☐
4. 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.)	☐	☐
5. Do you have a weakened immune system (i.e., from HIV or cancer) or are you on immunosuppressive drugs?	☐	☐
6. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐

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7. Do you have a history of or a risk factor for a blood clotting disorder?	□	□
8. Are you pregnant or breastfeeding?	□	□
9. Do you have dermal fillers?	□	□

10. Check all that apply to you:

- □ Am a female between ages 18 and 49 years old
- □ Am a male between ages 12 and 29 years old
- □ Have a history of myocarditis or pericarditis
- □ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 Infection
- □ Have a history of heparin-induced thrombocytopenia
- □ 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 _____

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 _____

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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	□ 1st Dose	□ 2nd Dose	□ 3rd Dose	.3ml	IM	LD RD			8/31/2022
Moderna (Red cap/blue border)	□ 1st Dose	□ 2nd Dose	□ 3rd Dose	.5ml	IM	LD RD			10/12/2022
Janssen (Johnson & Johnson)	□ 1st Dose			.5ml	IM	LD RD			5/5/2022
Novavax	□ 1st Dose	□ 2nd Dose	□ Booster Dose	.5ml	IM	LD RD			10/12/2022
Pfizer	□ Bivalent Booster Dose			.3ml	IM	LD RD			8/31/2022
Moderna	□ Bivalent Booster Dose			.5ml	IM	LD RD			10/12/2022

□ 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: