



COVID-19 Immunization Screening and Consent Form*

Recipient Name (please print)		Preferred Name	
DOB	Current Gender ID Indicate ID Below: <input type="text"/>	Key: W – Woman/Girl TW – Transgender Woman/Girl M – Man/Boy TM – Transgender Man/Boy NB – Non-Binary Person GNC – Gender Non-Conforming Q – Not Sure/Questioning NR – Chose not to Respond GNL - Gender not Listed (write-in) * Gender Pronouns: write-in by client’s name	
Sex Assigned at Birth Indicate Sex Below: <input type="text"/>	Key: M – Male F – Female I – Intersex NR – Chose not to Respond	Marital Status Indicate Status Below: <input type="text"/>	Key: S – Single D – Divorced M – Married W – Widowed V – Civil Union U – Unknown SEPARATED – Legally Separated PARTNER – Life Partner
Address		City	State Zip
		Email Address	
Parent/Guardian/ Surrogate (if applicable, please print)		Phone	Preferred Language
Ethnicity Indicate Ethnicity Below: <input type="text"/>	Ethnicity Key: DECL – Declined HIS – Hispanic Origin UNK - Unknown NHL – Non-Hispanic Origin	Indicate Race Below: <input type="text"/>	AIA – Native American or Alaskan ASN – Asian BAA – African American or Black WHT – White DECL – Declined OTH – Other or Multiracial NHP – Native Hawaiian or Pacific Islander
Primary Insurance Name	Primary Insurance ID#	Subscriber Name/DOB	Subscriber Relation to Patient
Primary Insurance Address	Primary Insurance Group #	Primary Insurance Phone #	
Secondary Insurance Name	Secondary Insurance ID#	Subscriber Name/DOB	Subscriber Relation to Patient
Secondary Insurance Address	Secondary Insurance Group #	Secondary Insurance Phone #	
Clinic/Office Site Where Vaccine is Administered	Primary Care Physician Address/Phone Number		

Screening Questionnaire

1.	Are you feeling sick today?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
2.	In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a health care provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
3.	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? <i>If yes, when did you receive the last dose?</i> Date: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
4.	Have you ever had an immediate allergic reaction (e.g. hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injection, or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5.	Are you pregnant or considering becoming pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
6.	Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
7.	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"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

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8.	Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
9.	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
10.	Have you received a previous dose of the Pfizer, Moderna or Janssen COVID-19 vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____ (if applicable)
11.	Have you received a previous dose of a COVID-19 vaccine authorized by the WHO but not by the FDA (AstraZeneca – VAXZEVRIA, Sinovac – CORONAVAC, Serum Institute of India – COVISHIELD, Sinopharm)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____ (if applicable)

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

Consent

I have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if my vaccine requires two doses, I will need to be administered (given) two doses of this vaccine in order for it to be effective. I have had a chance to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). 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 and provide surrogate consent). 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 plan, Medicare 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.

_____ Recipient/Surrogate/Guardian (Signature) recipient	_____ Date / Time	_____ Print Name	_____ Relationship to Patient (if other than recipient)
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Attestation of Uninsured Status

I acknowledge that I have been requested to present my insurance information. I understand that falsely claiming uninsured status is a breach of contract. I hereby sign below in attestation that at the time of vaccination I have no medical or pharmacy benefits.

_____ Recipient/Surrogate/Guardian (Signature) recipient	_____ Date / Time	_____ Print Name	_____ Relationship to Patient (if other than recipient)
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Area Below to be Completed by Vaccinator

Which vaccine is the patient receiving today?					
Vaccine Name	Administration			Fact Sheet Date	Manufacturer & Lot Number
Pfizer/ BioNTech	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose	<input type="checkbox"/> Third Dose		
Moderna	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose	<input type="checkbox"/> Third Dose		

Administration Site Left Deltoid Right Deltoid Left Thigh Right Thigh

Dosage 0.5 ml 0.3 ml

I have provided the patient (and/or parent, guardian or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained.

Vaccinator Signature: _____