

PROVIDER COVID-19 IMMUNIZATION CONSENT FORM

For COVID-19 Provider use only Clinic Name/Code: _____ Location type: (clinic, health department, pharmacy, etc.,) _____
 Address: _____ City: _____ County: _____
 State: _____ Zip Code: _____ Date of Service: _____

Person Receiving Vaccine:

(Legal) First Name: _____ MI: _____ Last Name: _____
 Date of Birth: ____/____/____

1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. If you answer "YES" you may not be able to receive the COVID-19 vaccine.

If YES refer to following websites at www.PfizerMedInfo.com, Moderna www.modernatx.com, Janssen www.janssencovid19vaccine.com. Refer to Pre-vaccination Checklist for COVID-19 vaccines to clarify questions: www.cdc.gov/vaccines/covid-19/downloads/pre-vaccination-screening-form.pdf.

	*YES	NO
Have you had a previous COVID-19 vaccine? If yes, what type and date?		
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?		
Have you ever had an allergic reaction to a COVID-19 vaccine or a COVID-19 vaccine component (including polyethylene glycol [PEG], which is found in some medications, or laxatives, and preparations for colonoscopy; or polysorbate, which is found in some vaccines, coated tablets, or IV steroids)?		
Have you ever had an allergic reaction that caused hives, swelling, respiratory distress (including wheezing) or anaphylaxis to a vaccine other than COVID-19 vaccine or an injectable medication that required treatment with epinephrine (EpiPen) or treatment at a hospital? Severe reaction or anaphylaxis to food, pet, venom, environmental, or oral medication allergies are not contraindications or precautions to vaccination with any COVID-19 vaccine.		
Do you have a bleeding disorder or are you taking a blood thinner?		
Have you received a hematopoietic cell transplant (HCT) or CAR-T-cell therapy since receiving COVID-19 vaccine? You should be revaccinated with a primary vaccine series at least 12 weeks after transplant or CAR-T-cell therapy.		
Did you develop myocarditis or pericarditis after the first dose of COVID-19 vaccine? You should not receive a subsequent dose of any COVID-19 vaccine. If you have developed myocarditis or pericarditis unrelated to an mRNA COVID vaccination, may receive COVID-19 vaccine after the episode has completely resolved.		
Are you immunocompromised? Do you have a condition that weakens your immune system? Are you receiving any immunosuppressive therapy? You are eligible to receive any FDA-authorized or FDA-approved COVID-19 vaccine unless you have a contraindication for some other reason. However, you will need special counseling about the vaccine.		
Have you had history of Heparin-Induced Thrombocytopenia (HIT) or Thrombosis with Thrombocytopenia Syndrome (TTS)? You may receive Pfizer-BioNTech or Moderna COVID-19 vaccine.		
Have you had history of Thrombosis with Thrombocytopenia Syndrome (TTS) following Janssen or any other adenovirus-vector (AstraZeneca) COVID-19 vaccine? Those who developed TTS after the initial Janssen vaccine should not receive a Janssen or any other adenovirus-vector COVID-19 vaccine booster dose. You may receive a mRNA COVID-19 vaccine.		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment or for post-exposure prophylaxis (PEP)? Defer vaccination 90 days after treatment and defer 30 days after PEP.		
Have you had Multisystem Inflammatory Syndrome (MIS)? Defer vaccination for at least 90 days. The decision for COVID-19 vaccination should be between the patient, their guardian, clinical team, or a specialist.		
Have you had history of Guillain-Barre Syndrome (GBS)? People with a history of GBS can receive any FDA-authorized or approved COVID-19 vaccine. People who had GBS after receiving Janssen vaccine should receive a Pfizer-BioNTech or Moderna COVID-19 vaccine booster at least 8 weeks after the Janssen dose.		

NOTE: CDC has made a clinical preference for persons 18 years and older to receive an mRNA COVID-19 vaccine over Janssen COVID-19 vaccine. Patients who cannot or unwilling to receive an mRNA vaccine will be able to access Janssen COVID-19 vaccine. The Janssen Fact Sheet must be provided and explained to the recipient or parent/legal representative about the risks and benefits and address any questions or concerns that the recipient or parent/legal representative may have prior to the vaccination. Recipients of Janssen COVID-19 vaccine should seek immediate medical attention if they develop shortness of breath, chest pain, leg pain or swelling, persistent abdominal pain, severe or persistent headaches or blurred vision, easy bleeding beyond the vaccination site within 30 days of a Janssen vaccination.

NOTE: A second dose of COVID-19 vaccine may be due in 21 days or 28 days after initial vaccine. Refer to your COVID-19 vaccination record card for proof of initial vaccine date and for second dose due date. Contact your vaccination provider, PCP, or your ADH Local Health Unit in 21 days or 28 days for more information.

2. RELEASE AND ASSIGNMENT: Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right.

Please sign here

My signature below indicates I have read, understand, and agree to section 2. **Release and Assignment** of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).
Signature of Patient/Parent/Guardian:

_____ Date _____

Initial Here: ☐ Vaccine Administrator acknowledgment of providing the most current Janssen COVID-19 Fact Sheet to vaccine recipient (explaining the risk and benefits) and addressing any questions or concerns with the vaccine recipient prior to vaccination with Janssen COVID-19.

Signature and Title of Vaccine Administrator: _____

Date Vaccine Administered: _____

MFG Codes: PFR=Pfizer, MOD=Moderna, ASZ=AstraZeneca, JSN=Janssen, NVX=Novavax, MSD=Merck
Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA

<input type="checkbox"/> IM	Route	Site Code	Dosage mL	MFG Code	Lot Number
<input type="checkbox"/> Ultra-cold COVID-19 Vaccine	<input type="checkbox"/> Pfizer-BioNTech (Purple Cap)	<input type="checkbox"/> Moderna		<input type="checkbox"/> AstraZeneca	<input type="checkbox"/> Novavax-Matrix-M1
<input type="checkbox"/> Pfizer-BioNTech (Orange Cap)				<input type="checkbox"/> Janssen (Johnson & Johnson)	<input type="checkbox"/> Other COVID-19 Vaccine
<input type="checkbox"/> Pfizer-BioNTech (Gray Cap)					

Co-administration of COVID-19 vaccines and other vaccines including flu vaccine. COVID-19 vaccines and other vaccines may be administered without regard to timing. This includes simultaneous administration of COVID-19 vaccination. Refer to the Pre-vaccination Checklist for COVID-19 vaccines to clarify medical history questions: www.cdc.gov/vaccines/covid-19/downloads/pre-vaccination-screening-form.pdf. Refer to Summary Document of Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized or Approved in the United States – Fact Sheet (cdc.gov).

COVID-19 VACCINE ADMINISTRATION (Completed by staff only)

Policy Holder's Employer Name: _____

Policy Holder Date of Birth: ____/____/____ Email Address: _____

(Legal) First Name: _____ MI: _____ Last Name: _____

REQUIRED POLICY HOLDER INFORMATION:

Member ID/Policy #: _____

☐ Insurance Company Name: _____

☐ Medicare Number: _____

☐ Medicaid/ARKids Number: _____

Patient's Relationship to Insurance Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

INSURANCE STATUS (Check appropriate box):

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic

Race: ☐ Asian ☐ Black/African American ☐ Native American/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

City: _____ State: _____ Zip Code: _____

Street Address: _____ P.O. Box _____ Apt. No. _____

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female Phone #: _____

(Legal) First Name: _____ MI: _____ Last Name: _____

PATIENT INFORMATION:

- RELEASE AND ASSIGNMENT:**
- I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits.
 - To read the Vaccine Recipient EUA Fact Sheet for Pfizer COVID-19 vaccine, Moderna COVID-19 vaccine, or Janssen COVID-19 vaccine visit <https://www.cdc.gov/vaccines/covid-19/eua/index.html> or visit your Local Health Unit or PCP to receive a printed copy of the EUA Fact Sheet.
 - I hereby acknowledge that I have reviewed a copy of the Provider's Privacy Notice.
 - I understand that information about this COVID-19 vaccination will be included in (WebIZ) Arkansas Immunization Information System.
 - To My Insurance Carrier(s):
 - I authorize the release of any medical information necessary to process my insurance claim(s).
 - I authorize and request payment of medical benefits directly to this COVID-19 Provider.
 - I agree that the authorization will cover all medical services rendered until I revoke the authorization.
 - I agree that the photocopy of this form may be used instead of the original.