COVID-19 Vaccination Consent under Emergency Use Authorization

PATIENT DEMOGRAPHIC INFORMATION

*Last Name:	*First Name:	Middle Initial:	
*Date of Birth / /	*Sex: Male ☐ Female ☐ Transgendered ☐ Other ☐		
*Race White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan Native ☐ None Specified ☐ Refused ☐		Hispanic Ethnicity: Yes ☐ No ☐ Unknown ☐ Refused ☐	
Address:		City:	
State: Zip:	Home Phone:	Cell Phone:	
Email:	Social Security Number:		
☐Private or employer insurance **Please bring photocopy of card**	☐ Medicare#:	☐Uninsured	☐Medicaid#:

HEALTH HISTORY

		YES	NO	UNKNOWN
1.	Are you feeling sick today?	☐	☐	☐
2.	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or Epi Pen or for which you had to go to the hospital?	☐	☐	☐
3.	Have you ever had a serious reaction after any vaccination or injectable medication including a previous dose of the COVID-19 vaccine?	☐	☐	☐
4.	In the past 14 days have you had contact with a confirmed COVID-19 patient	☐	☐	☐
5	Are you breastfeeding or pregnant?	☐	☐	☐
6.	Have you received passive antibody therapy as a treatment for COVID-19	☐	☐	☐
7.	Are you immunocompromised? *(taking medication or being treated for cancer, leukemia, HIV/AIDS or other immune system problems or taking medication that affects your immune system)*	☐	☐	☐
8.	Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
9.	Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICP to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The CICP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use of covered countermeasures identified in a PREP Act declaration. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV–2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any such product. Information about the CICP and filing a claim is available by calling 1-855-266-2427 or visiting https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine

PLEASE PRINT NAME of signature below

SIGNATURE OF PATIENT	RELATIONSHIP (if not patient)	TODAY'S DATE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

☐ I acknowledge and agree that I have received or have been advised of the Missouri Department of Health and Senior Services' Notice of Privacy Practices and where I can obtain any revisions made to this Notice.

---For Clinic Use only---

RX SARS-CoV-2 Vaccine Moderna 0.5ml Pfizer 0.3ml Astra Zeneca Johnson&Johnson 0.5ml

1st dose 2nd dose

Inject per pharmacy protocol by approved pharmacy vaccinator -Substitution Permitted

Dr Meredith Throop NPI:1386971943 ph: (314)535-5600

***By signing Consent form, you agree to wait for a minimum of 15 minutes to monitor for adverse events. If you leave prior to recommended monitoring time, the vaccinating agency cannot be held responsible.*

By initialing here I certify that I have reviewed and qualify for the current Priority Vaccination Phase located at_____
https://covidvaccine.mo.gov/priority/ **initials**