



COVID-19 Immunization Screening and Consent Form*

Recipient Name (please print) Preferred Name
DOB Current Gender ID Key: W - Woman/Girl TW - Transgender Woman/Girl M - Man/Boy
Sex Assigned at Birth Key: M - Male F - Female Marital Status Key: S - Single D - Divorced M - Married
Address City State Zip Email Address
Parent/Guardian/ Surrogate (if applicable, please print) Phone Preferred Language
Ethnicity Ethnicity Key: DECL - Declined HIS - Hispanic Race Race Key: AIA - Native American or Alaskan ASN - Asian
Origin NHL - Non-Hispanic WHT - White OTH - Other or Multiracial
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 table with 4 rows of questions and response options (Yes, No, Unknown).

5.	Have you ever had an immediate allergic reaction, such as hives, facial swelling, difficulty breathing or anaphylaxis, to any vaccine or shot or to any component of the COVID-19 vaccine, such as polyethylene glycol (PEG) or polysorbate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
6.	Have you had any vaccines in the past 14 days (2 weeks) including flu shot? <i>If yes, how long ago was your most recent vaccine? Date: _____</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
7.	Are you pregnant or considering becoming pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
8.	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
9.	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
10.	Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
11.	Have you received a previous dose of COVID-19 vaccine?	Click here to choose	<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)	Date / Time	Print Name	Relationship to patient, if other than recipient
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Telephonic Interpreter's ID # OR	Date / Time
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Signature: Interpreter	Date/ Time	Print: Interpreter's Name and Relationship to Patient
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Area Below to be Completed by Vaccinator			
Which vaccine is the patient receiving today?			
Vaccine Name	Administration		EUA Fact Sheet Date
Pfizer/ BioNTech	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose	
Moderna	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose	
Astra-Zeneca	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose	
			Manufacturer & Lot Number

Janssen	<input type="checkbox"/> Single Dose		
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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: _____

*** Use of this form is optional.**