



PART 2: COVID-19 VACCINE SCREENING & CONSENT

**THIS FORM MUST BE COMPLETED & SENT WITHIN 24 HOURS OF APPOINTMENT.
PLEASE BRING THIS PAGE TO THE APPOINTMENT AS WELL!**

Recipient Name: _____ **Date of Birth:** _____

Have you received a previous dose of the COVID-19 vaccine? Moderna Pfizer Other → **Date:** _____

If you answer “Yes” to any questions below, please call us and speak to the doctor before your appointment:

	Yes	No	Don't Know
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	
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, exposure or travel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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? Date: _____</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you carry an epipen? Or 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 have you had a severe allergic reaction (anaphylaxis) to anything?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any medical conditions for which you receive any type of treatment? (e.g. asthma, heart disease, etc.) Please list below: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 | By signing, 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 the 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 any monies/benefits 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.

Signature of Vaccine Recipient or Parent (if under 18): _____

Print Parent Name (if under 18): _____ **Date of Service (your appointment):** _____