COVID-19 Immunization Screening and Consent Form **Name/Acct. #:**______________________________

Question			
Are you feeling sick today?	Y	N	
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?	Y	N	UnK
Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? If yes, when was the last dose? DATE__________________________	Y	N	UnK
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?	Y	N	UnK
Are you pregnant or considering becoming pregnant?	Y	N	UnK
Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?	Y	N	UnK
Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anti-cancer drugs, or have you had any radiation treatments?	Y	N	UnK
Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?	Y	N	UnK
Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	Y	N	UnK
Have you received a previous dose of the Pfizer, Moderna or Janssen COVID-19 vaccine?	Y	N	UnK
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)?	Y	N	UnK
BOOSTER			
Are you 5 yrs or older and have you received 2 doses of Pfizer, the second dose being at least 5mo ago?	Y	N	Date:
Have you received 2 doses of the Moderna, the second dose being at least 5 mo ago?	Y	N	Date:
Do you have a history of multisystem inflammatory syndrome?	Y	N	Date:
If you had a previous dose of Janssen, did you develop thrombosis with thrombocytopenia syndrome?	Y	N	UnK

- Your child is being offered a COVID-19 vaccine made by Pfizer-BioNTech and is approved by the U.S. Food and Drug Administration (FDA) for people 6mos and older.

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/three doses, I will need to receive two/three doses to be considered fully vaccinated. Further, I understand that a booster dose of COVID-19 vaccine is recommended at least 2 months following the first dose of Janssen vaccine (if I am age 18 or older), or at least 5 months following the second dose of Pfizer-BioNTech (if I am age 5yr or older) or Moderna COVID-19 vaccine (if I am age 18 or older), to increase my protection.

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.

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Patient/Parent Signature **Print Name** **Relationship to patient** **Date**

Area Below to be Completed by Vaccinator			
Which vaccine is the patient receiving today?			
Vaccine Name	Administration	EUA Fact Sheet	Manufacturer & Lot #
Pfizer/ BioNTech	□ 1st Dose □ 2nd Dose □ 3rd Dose (6mo-4yr) □ Booster		

Administration Site □ Left Deltoid □ Right Deltoid □ Left Thigh □ Right Thigh
Dosage □ 0.2 ml □ 0.3 ml
Age Group □ 6mo-4 yr □ 5-11 yr □ 12 yr and older

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

Vaccinator Signature: ____ (updated 6-22-2022)