**COVID-19 Vaccination Screening & Consent Form**

**Section 1: PERSONAL INFORMATION**

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| --- | --- | --- | --- | --- | --- | --- |
| Last Name: |  | First Name: |  | DOB: |  | (mm/dd/yyyy) |
| Address: |  | City: |  | State: |  | Zip Code: |  | Phone: |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sex** | FemaleMale | **Race** | American Indian or Alaska NativeAsianBlack or African American | Native Hawaiian or Other Pacific IslanderWhiteUnknown | **Ethnicity** | Hispanic or LatinoNot Hispanic or LatinoUnknown |

**Section 2: CONSENT TO RECEIVE THE COVID-19 VACCINE (please INITIAL consent, agreement & understanding):**

\_\_\_\_\_\_ **Vaccine Consent:** I have been given a copy and have read, or have had explained to me, the information in the

(Initials)

FACT SHEET FOR RECEIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA) regarding the vaccine that I receive. I request that the COVID-19 vaccination be given to me.

\_\_\_\_\_\_ **Financial Agreement:** I acknowledge that an administration fee may be billed to my insurance carrier, third-party

(Initials)

payers, Medicare or Medicaid for this service. I authorize the release of any medical or other information necessary to process this claim.

\_\_\_\_\_\_ **Privacy:** I acknowledge that a copy of the Notice of Privacy Practices has been made available to me. We may

(Initials)

disclose your vaccination information from this visit for public health purposes.

\_\_\_\_\_\_ I understand that I must remain in the observation area for 15 minutes post vaccination if I do not have a history of

(Initials)

allergic reaction or 30 minutes if I have a history of severe allergic reaction.

**Section 3: PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS:**

|  |
| --- |
| 1. Are you feeling sick today? Yes No Don’t Know |
| 2. Have you ever received a COVID-19 vaccine? Yes No Don’t Know* If yes, which vaccine product did you receive?

 Pfizer Moderna Another product \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g. anaphylaxis] that required treatment with epinephrine or EpiPen© or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) Yes No Don’t Know A component of the COVID-19 vaccine including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures. Yes No Don’t Know Polysorbate Yes No Don’t Know A previous dose of COVID-19 vaccine  |
| 4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?(This would include a severe allergic reaction [e.g. anaphylaxis] that required treatment with epinephrine or EpiPen© or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) Yes No Don’t Know  |
| 5. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any other vaccine or injectable medication? This would include food, pets, environmental, or oral medication allergies. Yes No Don’t know |
| 6. Have youreceived any other vaccine in the last 14 days? Yes No Don’t know |
| 7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? Yes No  Don’t Know |
| 8. Have you received passive antibody therapy (monoclonal antibodies, convalescent plasma) as treatment for COVID-19? Yes No Don’t Know |
| 9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? Yes No Don’t Know |
| 10. Do you have a bleeding disorder or are you taking a blood thinner? Yes No Don’t Know |
| 11. Is the recipient pregnant or breastfeeding? Yes No Not sure Not applicable |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR CLINIC USE ONLY:**

**Vaccine Administration Reporting Information**

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| Based on the recipient’s current condition and medical history, should the COVID-19 vaccine be administered?  Yes No |

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| --- | --- | --- | --- |
| CVX (Product): | 208 (SARS-COV-2, mRNA, spike protein) | Lot Number (Unit of Use (UOU) or Unit of Sale (UoS): |   |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Dose #: |  | MVX (Manufacturer): | PFR (Pfizer) | Dose: | .3 ml |

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| --- | --- | --- | --- | --- | --- | --- |
| Route: | IM | Date Administered: |  | Time Administered: |  | AM / PM |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Site: |   | Right Deltoid  |  | Left Deltoid |  |  |  |

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| --- | --- | --- | --- | --- |
| Administered By (Please print): | Last Name: |  | First Name: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signature: |  | Facility & Address: | Hilo Medical Center | 1190 Waianuenue Ave.,Hilo, HI 96720 |

|  |  |  |  |
| --- | --- | --- | --- |
| Ordering Physician: | **Kathleen Katt, MD** | Signature: | See standing orders dated 12/16/2020 |

**FOR CLINIC RECEPTION USE ONLY (Verbal Authorization for Minor):**

**Patient Confirmed:  Yes**

|  |  |
| --- | --- |
| Name: | Relationship: |
| Verbal 1: | Verbal 2: |