COVID-19

Preventing Infection | Protecting Patients & Staff

FOR CLINIC USE ONLY:
☐1st Dose Community
☐ 2nd Dose Community

COVID-19 Vaccination Screening & Consent Form

Section 1: PERSONAL INFORMATION

Last Name: _____ First Name: _____ DOB: _____ (mm/dd/yyyy)

Address: _____ City: _____ State: _____ Zip Code: _____ Phone: _____

Sex ☐ Female ☐ Male	**Race** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American	☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown	**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

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

_____ (Initials) **Vaccine Consent:** I have been given a copy and have read, or have had explained to me, the information in the 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.

_____ (Initials) **Financial Agreement:** I acknowledge that an administration fee may be billed to my insurance carrier, third-party payers, Medicare or Medicaid for this service. I authorize the release of any medical or other information necessary to process this claim.

_____ (Initials) **Privacy:** I acknowledge that a copy of the Notice of Privacy Practices has been made available to me. We may disclose your vaccination information from this visit for public health purposes.

_____ (Initials) I understand that I must remain in the observation area for 15 minutes post vaccination if I do not have a history of 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 you received 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: _____

Revised: March 12, 2021

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Vaccine Administration Reporting Information

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

CVX (Product): 212 SARS-COV-2 (COVID-19) vaccine, vector non-replicating, recombinant spike protein-Ad26

Lot Number (Unit of Use (UOU) or Unit of Sale (UoS): _____

Dose #: _____ MVX (Manufacturer): Janssen Dose: .5 ml

Route: IM Date Administered: _____ Time Administered: _____ AM / PM

Site: ☐ Right Deltoid ☐ Left Deltoid

Administered By (Please print): Last Name: _____ First Name: _____

Signature: _____ Facility & Address: Hilo Medical Center 1190 Wainuenue Ave. Hilo, HI 96720

Ordering Physician: **Kathleen Katt, MD** Signature: See standing orders dated 5/12/2020

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

Patient Confirmed: ☐ **Yes**

Name:	Relationship:
Verbal 1:	Verbal 2: