☐1st Dose Pfizer
☐ 2nd Dose Pfizer
☐ 3rd Dose Booster Pfizer
☐ Additional Dose Pfizer

COVID-19

Preventing Infection | Protecting Patients & Staff

For Internal Use:
Patient Name:
Account Number:
Medical Record #:

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) **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.

Booster/Additional Vaccinations ONLY: Which vaccine did you receive previously?

☐ **Pfizer (COMIRNATY):** Dose #1 Date: _____ and Dose #2 Date: _____

☐ **Moderna:** Dose #1 Date: _____ and Dose #2 Date: _____

☐ **Janssen (J&J):** Dose #1 Date: _____

CDC recommends that the following groups are allowed to receive an additional dose of mRNA COVID-19 Pfizer-BioNTech's or Moderna COVID-19 Vaccine at least 28 days after completing their Pfizer-BioNTech or Moderna primary series (i.e., the first 2 doses of a COVID-19 vaccine):
(Please check if applies to you)

☐ Immunocompromised Individual

CDC recommends that the following groups are allowed to receive a booster shot of Pfizer-BioNTech's COVID-19 Vaccine at least 6 months after completing their primary series of Pfizer-BioNTech's or Moderna vaccine (i.e., the first 2 doses of a Pfizer -BioNTech's or Moderna COVID-19 vaccine):
(Please check all that apply)

☐ Individual aged 65 years and older

☐ Individual aged 18 years and older that is a resident in a long-term care setting

☐ Individual aged 18 years and older with underlying medical conditions

☐ Individual aged 18 years and older who live in a high-risk setting

☐ Individual aged 18 years and older at increased risk for COVID-19 exposure and transmission because of occupational or institutional setting

CDC recommends that the following groups are allowed to receive a booster dose of Pfizer-BioNTech's COVID-19 Vaccine at least 2 months after completing their primary does of Janssen (J&J) vaccine:
(Please check all that apply)

☐ Individual aged 18 years and older

*** By signing below, I attest that I am eligible for a booster vaccine for the selected recommended conditions above.**

Signature: _____ **Date:** _____

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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 ☐ Janssen (J& J) ☐ 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. Check all that apply to you
   - ☐ Am a female between ages 18 and 49 years old
   - ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies.
   - ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
   - ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
   - ☐ Have a weakened immune system (i.e., HIV infection, cancer)
   - ☐ Take immunosuppressive drugs or therapies
   - ☐ Have a bleeding disorder
   - ☐ Take a blood thinner
   - ☐ Have a history of heparin-induced thrombocytopenia (HIT)
   - ☐ Am currently pregnant or breastfeeding
   - ☐ Have received dermal fillers

*☐ By checking this box, the individual providing the information confirms the above information is accurate and that they meet the policy requirements for age in their state/jurisdiction. The individual authorizes the administration of the COVID-19 vaccine to themselves or the person named above for whom they are the parent/representative/guardian. They have received the EUA Fact Sheet(s) for COVID-19 vaccine(s). They acknowledge that they have received a copy of the Privacy Policy Terms and Conditions.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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FOR CLINIC USE ONLY:

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): COMIRNATY 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

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 12/16/2020

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

Patient Confirmed: ☐ **Yes** **Name:**_____ **Relationship:**_____