COVID-19

Preventing Infection | Protecting Patients & Staff

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

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		Race			Ethnicity	
	☐ Female		☐ American Indian or Alaska Native	☐ Native Hawaiian or Other Pacific Islander		☐ Hispanic or Latino
	☐ Male		☐ Asian	☐ White		☐ Not Hispanic or Latino
			☐ Black or African American	☐ Unknown		☐ 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 Individuals aged 5 years and older

CDC recommends that the following groups are allowed to receive a booster shot of Pfizer-BioNTech's or Moderna COVID-19 Vaccine at least **5 months** after completing their primary series of **Pfizer-BioNTech's** (i.e., the first 2 doses of a Pfizer -BioNTech's COVID-19 vaccine):
(Please check all that apply)

☐ Individual aged 12 years and older

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

☐ Individual aged 18 years and older

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:** ____________________

Revised: January 6, 2022

COVID-19

Preventing Infection | Protecting Patients & Staff

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

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

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: ____________________

Hilo Medical Center

Vaccination Clinic Registration Form

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

Patient Information

Patient Legal Last Name	Patient Legal First Name	Middle Initial(s)	Suffix: ☐ Jr ☐ Sr ☐ I ☐ II ☐ III
Date of Birth / /	Sex: ☐ Male ☐ Female	Social Security Number – For Patient Identification - -	
Primary Phone No.: Type: ☐ Cell ☐ Phone ☐ Work		Marital Status: ☐ Divorced ☐ Life Partner ☐ Never Married ☐ Legally Separated ☐ Married ☐ Widow/Widower	
Secondary Phone No.: Type: ☐ Cell ☐ Phone ☐ Work			

Street (Home) Address	City	State	Zip	Race:
Mailing Address	City	State	Zip	Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic ☐ Unknown/Refused

Employment Status: ☐ Disabled ☐ Retired ☐ Unemployed ☐ Full Time ☐ Part Time ☐ Active Military

If Employed, Employer Name and Address:	Employer Phone No.:

Insurance Information

☐ **I Do NOT Have Health Insurance**

Primary Insurance	**Subscriber Number**	I provided this Insurance card today: ☐ Yes ☐ No
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Other:		
Complete Subscriber name & Date of birth below, if Subscriber is NOT the patient		
Subscriber Last Name:	Subscriber First Name:	Subscriber Date of Birth:

Secondary Insurance	**Subscriber Number**	I provided this Insurance card today: ☐ Yes ☐ No
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Other:		
Complete Subscriber name & Date of birth below, if Subscriber is NOT the patient		
Subscriber Last Name:	Subscriber First Name:	Subscriber Date of Birth:

Tertiary Insurance	**Subscriber Number**	I provided this Insurance card today: ☐ Yes ☐ No
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Other:		
Complete Subscriber name & Date of birth below, if Subscriber is NOT the patient		
Subscriber Last Name:	Subscriber First Name:	Subscriber Date of Birth:

Submit this completed form to the registrar after you have received your vaccine.

COVID-19

Preventing Infection | Protecting Patients & Staff

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

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

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 Waianuenue Ave. Hilo, HI 96720

Ordering Physician: **Kathleen Katt, MD** Signature: See standing orders dated 1/7/2022