COVID-19 VACCINE IMMUNIZATION SCREENING AND CONSENT FORM

Clinic: _____ Location: _____

PATIENT INFORMATION (Person Receiving Vaccine):

(Legal) First Name: _____ MI: ____ Last Name: _____
Date of Birth: _____ / _____ /_____ Cell Phone #: (_____) _____
Street Address: _____ P.O. Box _____ Apt. No. _____
City: _____ State: _____ Zip Code: ☐☐☐☐☐
County: _____E-Mail: _____
Social Security Number: _____ / _____ / _____

Gender: ☐ Male ☐ Female ☐ Transgender

Race: ☐White ☐Black/African American ☐Native American /Alaska Native ☐ Asian
☐ Native Hawaiian/Other Pacific Islander ☐Other (If Multiracial: Please select primary 2 races)

Ethnicity: ☐ Not Hispanic/Latino or ☐Hispanic/Latino

1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. If you answer "YES" you may not be able to receive the COVID-19 vaccine.	***YES**	**NO**
Have you had a previous COVID-19 vaccine? If yes, brand: date:		
Have you had any vaccines (e.g. influenza vaccine, etc.) within the previous 14 days? COVID-19 vaccine should be administered alone with a minimal interval of 14 days before or after any other vaccine.		
Do you have a fever today? Are you sick today? Have you tested positive for or been diagnosed with COVID-19 infection within the last 10 days? Are you currently in isolation or quarantine for known exposure to COVID-19?		
Do you have any allergies?		
Have you ever had severe allergic reaction (anaphylactic reaction) such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness, to any vaccine, vaccine component or injectable therapy or to any component of the vaccine you are receiving today? Vaccine components are listed in the vaccine fact sheet for recipients and caregivers.		
Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive COVID-19 vaccine, a discussion with your healthcare provider can help make informed decision.		
Do you have a bleeding disorder or are you on a blood thinner?		
Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe obesity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive COVID-19 vaccine unless otherwise contraindicated.		
Have you received any COVID-19 antibody therapy (e.g. Regeneron, Bamlanivimab, COVID Convalescent Plasma, etc.)? If yes, Vaccination should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced immune responses.		
NOTE: A second dose of Moderna COVID-19 vaccine **is** due 28 days after initial vaccine. A second dose of Pfizer COVID-19 vaccine is due 21 days after initial vaccine. Janssen (Johnson and Johnson) COVID-19 vaccine is a single dose vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Bring your card with you for future vaccine doses. Keep your COVID-19 vaccination record card for your records and as proof of vaccination dates.		

The Providers Privacy Notice is available at the clinic site or accompanies this form.

NEXT: COMPLETE BACK SIDE OF THIS FORM → → → →

2. **Please read the RELEASE AND ASSIGNMENT section below**

RELEASE AND ASSIGNMENT:

- **I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient Emergency Use Authorization Fact Sheet for each vaccine visit the website www.cvdvaccine.com to view current EUA: or you may also visit the Local Health Unit or private provider to receive a printed copy of the EUA Fact Sheet.**
- **I give consent to this COVID-19 provider/staff for the individual named below to be vaccinated with COVID-19 vaccine.**
- **I hereby acknowledge that I have reviewed a copy of the Provider's Privacy Notice.**
- **I understand that information about this COVID-19 vaccination will be included in (WebIZ) Arkansas Immunization Information System.**

To My Insurance Carrier(s):

- **I authorize the release of any medical information necessary to process my insurance claim(s).**
- **I authorize and request payment of medical benefits directly to this COVID-19 Provider.**
- **I agree that the authorization will cover all medical services rendered until I revoke the authorization.**
- **I agree that the photocopy of this form may be used instead of the original.**

INSURANCE STATUS (Check appropriate box):

Patient's Relationship to Insurance Policy Holder: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

☐ **Medicaid/ARKids Number:** ☐☐☐☐☐☐☐☐☐☐☐☐

☐ **Medicare Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐ **Insurance Company Name**: _____

Member ID/Policy #: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

REQUIRED POLICY HOLDER INFORMATION:

(Legal) First Name: _____ **MI:** ____ **Last Name:** _____

Policy Holder Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ **Email Address:** _____

Policy Holder's Employer Name: _____

MY SIGNATURE BELOW INDICATES THAT I WISH TO RECEIVE A COVID-19 VACCINATION, AND

I have answered all questions on this form to the best of my knowledge, including **1. Medical History**, and
I have read, understand and agree to section **2. Release and Assignment** of the COVID-19 Immunization Consent Form, including the Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA) for the vaccine I will receive today.

Signature of Patient/Parent/Guardian:

↓ PLEASE SIGN HERE ↓

_____Date_____

(Completed by staff only) COVID-19 VACCINE ADMINISTRATION

Refer to product-specific Emergency Use Authorization (EUA) fact sheet for COVID-19 providers

Frozen COVID-19 Vaccine	**Ultra-cold COVID-19 Vaccine**	**Refrigerated COVID-19 Vaccine**
☐ Moderna (**Dosage mL: 0.50 ml**)	☐ Pfizer-BioNTech **(Dosage mL: 0.30)**	☐ Janssen (**Dosage mL: 0.50 ml**)
Route: ☑ **IM** **Site:** Deltoid Muscle: ☐ **Right** ☐ **Left**	**Lot / Expiration:**	

MFG Codes: PFR=Pfizer, MOD=Moderna, ASZ=AstraZeneca, JSN=Janssen, NVX=Novavax, MSD=Merck
Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA

Date Vaccine Administered: _____/_____/_____ **Time:** _____

Signature and Title of Vaccine Administrator: _____

(Form 03/17/21)