Montgomery County Health Department
11191 Illinois Route 185
Hillsboro, IL 62049
(217) 532-2001

SECOND DOSE

COVID-19 Immunization Screening and Consent Form

Recipient Name (please print)	DOB

	Screening Questionnaire			
1.	Are you feeling sick today?	□ Yes	□ No	
2.	Have you ever received a dose of COVID-19 vaccine?	□ Yes	□ No	□ Unknown
3.	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something?	□ Yes	□ No	□ Unknown
4.	Was the severe allergic reaction after receiving a COVID-19 vaccine?	□ Yes	□ No	□ Unknown
5.	Was the severe allergic reaction after receiving another vaccine or another injectable medication?	□ Yes	□ No	□ Unknown
6.	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	□ Yes	□ No	□ Unknown
7.	Have you received another vaccine in the last 14 days?	□ Yes	□ No	□ Unknown
8.	Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	□ Yes	□ No	□ Unknown
9.	Do you have a weakened immune system or do you take immunosuppressive drugs or therapies?	□ Yes	□ No	□ Unknown
10.	Do you have a bleeding disorder or are you taking a blood thinner?	□ Yes	□ No	□ Unknown
11.	Are you pregnant or breastfeeding?	□ Yes	□ No	□ Unknown

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

CONSENT

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

If you did not receive your first dose from MCHD, please complete page 2.

X Sign Here

Recipient/Surrogate/Guardian (Signature) Date Relationship to patient, if other than recipient

Area Below to be Completed by Vaccinator			
Which vaccine is the patient receiving today?			
Vaccine Name	Manufacturer & Lot Number	Administration	EUA Fact Sheet Date

Administration Site □ Left Deltoid □ Right Deltoid Dosage □ 0.3 □ 0.5

□ I have reviewed side effects with patient (and parent, guardian or surrogate, as applicable)

□ I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered correctly and to the best of my ability.

Vaccinator Signature: _____ Vaccination Time: _____

Please complete the section below if you did not receive your first dose from MCHD.

Legal Gender	Primary Care Physician Name/City/Phone Number	
Street Address	City State Zip	
Ethnicity Circle one: HIS – Hispanic Origin NHL – Non-Hispanic Origin UNK - Unknown DECL – Declined	Race Circle one: WHT – White ASN – Asian DECL – Declined AIA – Native American or Alaskan BAA – African American or Black NHP – Native Hawaiian or Pacific Islander OTH – Other or Multiracial	Phone Email Address *(optional)*
Medicare #	Insurance Company: Group Number: ID Number: Subscriber Name*: **If you are the subscriber please enter "SELF"* Subscriber Date of Birth:	
Do you have a Medicare Supplement? Yes No (If yes, please complete insurance company information)	Medicaid (IDPA) #	