TWO RIVERS PUBLIC HEALTH DEPARMENT INFLUENZA/COVID-19 CONSENT FORM

PATIENT INFORMATION

SCHOOL NAME	CITY

LAST NAME	FIRST NAME	MI	MAIDEN NAME (IF APPLICABLE)

DATE OF BIRTH	AGE	SEX	MOTHER'S MAIDEN NAME (FIRST AND LAST)	PHONE
_ _/ _ _/ _ _ _ _		M F		( )

STREET ADDRESS	P.O.BOX (IF APPLICABLE)	CITY	STATE	ZIP

RACE □ WHITE □ ASIAN □ AMERICAN INDIAN/ALASKAN NATIVE □ AFRICAN AMERICAN

ETHNICITY □ NOT HISPANIC OR LATINO □ HISPANIC OR LATINO

INSURANCE INFORMATION

RELATIONSHIP OF PAITENT TO INSURANCE SUBSCRIBER □ SELF □ SPOUSE □ CHILD □ OTHER

SUBSCRIBER NAME (IF DIFFERENT THAN ABOVE)	SUBSCRIBER BIRTH DATE _ _/ _ _/ _ _ _ _	SOCIAL SECURITY #

STREET ADDRESS (IF DIFFERENT THAN ABOVE)	CITY	STATE	ZIP
			-

PHOTO OF CARD (FRONT & BACK) □ DRCHRONO □ PHOTO COPY ATTACHED □ STAFF DEVICE (DEVICE #)

INSURANCE PROVIDER

☐ BLUE CROSS BLUE SHIELD
☐ UNITED HEALTH CARE
☐ MEDICAID: **CIRCLE ONE**
UHC NTC WELLCARE
☐ MEDICARE (SS# REQUIRED)
☐ NO INSURANCE
☐ OTHER:_____

SCREENING QUESTIONNAIRE- Questions must be completed before vaccine is administered

	YES	NO	DON'T KNOW
DO YOU HAVE ALLERGIES TO EGGS OR A VACCINE COMPONENT?			
HAVE YOU EVER HAD DIFFICULTY BREATHING AFTER RECEIVING A VACCINATION?			
HAVE YOU HAD A SEIZURE, BRAIN/NERVOUS SYSTEM DISORDER OR GUILLAIN-BARRE?			

I GIVE CONSENT to the **Two Rivers Public Health Department** and its staff to vaccinate the person listed on this form. I have read or had explained to me the Emergency Use Authorization or been provided a Vaccine Information Statement and understand the risks and benefits. I hereby grant permission to Two Rivers Public Health Department to release any pertinent information to the above insurance company upon request and any physicians to whom I might be referred. I agree and acknowledge that TRPHD or any of its volunteer's or partnering agencies, are not liable for the actions or omissions of, or the instructions given by the staff, volunteers, or partnering agencies who perform the vaccination.

_____/_____/_____

Authorized Signature (*client, if 19 or older, or parent/legal guardian)* Today's Date: *(month/day/year)*

PLEASE INDICATE WHICH VACCINATION(S) YOU WOULD LIKE THE INDIVIDUAL LISTED ABOVE TO RECEIVE

COVID-19 ☐ **INFLUENZA** ☐

VACCINE MANUFACTUER	LOT/EXP	SITE	NURSE/DATE
COVID-19		LA RA	
		LA RA	
		LA RA	
		LA RA	
INFLUENZA		LA RA	
		LA RA	
		LA RA	
		LA RA	

TRPHD STAFF ONLY - VACCINE RECIPIENT'S TEMPERATURE TODAY: _____

Dr. Chrono_____/_____NESIIS___/_____Billed_____/_____ Paid Cash/Donation_____

Special Note:_____

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Name _____

Birthdate _____

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• Did you bring your vaccination record card or other documentation? *(yes/no)*	☐	☐	
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 caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including either of the following:			
○ Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• 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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

5. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ 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 herparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists