HR*Support*

2021 COVID-19 Vaccination Screening Form

PATIENT (person receiving vaccine)

Last Name: **First Name:** **Date of Birth:**

Address, City, Zip Code **Female**____**Male**_____**Age**_____ Must be 18 for Moderna
Must be 12 for Pfizer

Cell Phone: **Email:** Must be 18 for Johnson & Johnson

Race:____American Indian or Alaskan Native__Asian____Indian_____Black or African American__Native Hawaiian or Other Pacific Islander
____Other Race____Chinese____Unknown____White **ETHNICITY:** _Hispanic or Latino ____Not Hispanic or Latino ____Unknowns

Parent/Legal Guardian (necessary if patient is UNDER 18 years old)

Name: _____ **Signature** _____ **Phone Number:** _____

Screening Checklist for Contraindications to COVID-19 Vaccination

For the person getting vaccinated today to be eligible to receive the COVID-19 vaccine, you must read, answer all the questions and sign this consent form. Depending on your answers you and/or your child will either receive the Pfizer, the Moderna, or the Johnson & Johnson COVID-19 vaccine or be asked additional questions. Please read the Emergency Use Authorization (EUA) form we have provided to you by email. Both vaccines require 2 doses. You will need to return in 21 days for Pfizer or 28 days for the Moderna vaccine. Please note: For minors, especially between 12yrs to 15yrs, a parent/legal guardian must provide informed consent and be present for the minor to be vaccinated.

1. Are you feeling sick today?	____Yes____No
2. Have you received any other vaccines in the past 14 days?	____Yes____No
3. Have you ever received a dose of COVID-19 vaccine?	___Yes____No
If YES, which vaccine product? Pfizer Moderna Johnson & Johnson Other Product	
4. Have you had a severe allergic reaction to mRNA COVID-19 vaccines or their contents: polysorbate or polyethylene glycol?	____Yes____No
5. Have you received any monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days?	____Yes____No
6. Have you had a severe allergic reaction to food, pet, insect stings, medications, or other vaccines?	____Yes____No
7. Do you have a weakened immune system caused by HIV infection or cancer or do you take immunosuppressive drugs or therapies?	____Yes____No
8. Are you pregnant or breastfeeding? _____Yes_____No	
9. Written or verbal consent for vaccine administration obtained from patient/parent?	_____Yes_____No
10. Written or digital Emergency Use Authorization Fact Sheet/Vaccine Information Sheet provided to patient/parent?	_____Yes____No

Vaccination Consent **This acknowledgment must be signed on the date the vaccine is administered by the person to receive the vaccine, or by the parent or legal guardian.**

Acknowledgment:

I acknowledge that I have received, read, and understood the emergency use authorization (EUA) fact sheet on the vaccine(s) I have elected to receive. I further acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and (b) the applicable Provider may disclose my vaccination information to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Centers for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry for purposes of care coordination. I also understand that I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the applicable Provider: (a) the disclosure of my vaccination information by the applicable Provider to the State Registry; or (b) the State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State Registry, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws or federal law may permit certain disclosures of my vaccination information to or through the State Registry or to Government Agencies as required or permitted by law. I agree that my insurance provider or health plan may be charged for any requested items and services not covered by my benefits. HR Support may contact me, through auto-dialing, pre-recorded calls, texts, or any other electronic means regarding vaccine second-dose reminders. I release HR Support from all claims relating directly or indirectly to the administration of the vaccine to myself or to the child.

I, the undersigned, certify that all the above information is true and correct to the best of my knowledge.

Signature of Patient, Parent or Legal Guardian: _____ **Date:** _____

Insurance Provider:_____

Insurance/Group Number:_____

Insurance/ID Card Image

ID Number:_____

I attest that I do not have health insurance (initial)__

For Administrative Use Only		
PFIZER	**MODERNA**	**JOHNSON&JOHNSON**

Vaccinator name (print)	
Vaccine Administration Site (specific site) Deltoid L / R Other:	
Date of Dose #1	Date of Dose #2
CLINIC DATE/LOCATION:	
EUA Provided Y / N	Initials & Date Entered into CPS/HF