



## COVID-19 Immunization Screening and Consent Form\*

Recipient Name (please print)		Preferred Name	
DOB	Current Gender ID Indicate ID Below: <input style="width: 80px; height: 25px;" type="text"/>	<b>Key:</b> W – Woman/Girl    TW – Transgender Woman/Girl    M – Man/Boy TM – Transgender Man/Boy    NB – Non-Binary Person    GNC – Gender Non-Conforming Q – Not Sure/Questioning    NR – Chose not to Respond GNL - Gender not Listed (write-in) * Gender Pronouns: write-in by client’s name	
Sex Assigned at Birth Indicate Sex Below: <input style="width: 80px; height: 25px;" type="text"/>		<b>Key:</b> M – Male    F – Female I – Intersex    NR – Chose not to Respond	
Marital Status Indicate Status Below: <input style="width: 80px; height: 25px;" type="text"/>		<b>Key:</b> S – Single    D – Divorced    M – Married W – Widowed    V – Civil Union    U – Unknown SEPARATED – Legally Separated PARTNER – Life Partner	
Address		City	State    Zip
Email Address			
Parent/Guardian/ Surrogate (if applicable, please print)		Phone	Preferred Language
Ethnicity Indicate Ethnicity Below: <input style="width: 80px; height: 25px;" type="text"/>	<b>Ethnicity Key:</b> DECL – Declined HIS – Hispanic Origin NHL – Non-Hispanic Origin UNK – Unknown	Race Indicate Race Below: <input style="width: 80px; height: 25px;" type="text"/>	<b>Race Key:</b> AIA – Native American or Alaskan    ASN – Asian BAA – African American or Black DECL – Declined NHP – Native Hawaiian or Pacific Islander WHT – White    OTH – Other or Multiracial
Primary Insurance Name	Primary Insurance ID#	Subscriber Name/DOB	Subscriber Relation to Patient
Primary Insurance Address	Primary Insurance Group #	Primary Insurance Phone #	
Secondary Insurance Name	Secondary Insurance ID#	Subscriber Name/DOB	Subscriber Relation to Patient
Secondary Insurance Address	Secondary Insurance Group #	Secondary Insurance Phone #	
Clinic/Office Site Where Vaccine is Administered	Primary Care Physician Address/Phone Number		

### Screening Questionnaire

1.	Are you feeling sick today?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2.	In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a health care provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
3.	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? <i>If yes, when did you receive the last dose? Date: _____</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
4.	Have you ever had an immediate allergic reaction (e.g. hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injection, or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
5.	Are you pregnant or considering becoming pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

6.	Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
7.	Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
8.	Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
9.	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
9.	Are you 65 years old or older?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
10.	Are you 18 years old or older AND a resident of a long-term care facility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
11.	Are you 50 through 64 years old AND have one or more of the following conditions (due to increased risk of moderate or severe illness or death from the virus that causes COVID-19): 1.) Cancer (current or in remission, including 9/11-related cancers); 2.) Chronic kidney disease; 3.) Pulmonary Disease, including but not limited to, COPD (chronic obstructive pulmonary disease), asthma (moderate-to-severe), pulmonary fibrosis, cystic fibrosis, and 9/11 related pulmonary diseases; 4.) Intellectual and Developmental Disabilities including Down Syndrome; 5.) Heart conditions, including but not limited to heart failure, coronary artery disease, cardiomyopathies, or hypertension (high blood pressure); 6.) Immunocompromised state (weakened immune system) including but not limited to solid organ transplant or from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, use of other immune weakening medicines, or other causes; 7.) Severe Obesity (BMI 40 kg/m <sup>2</sup> or higher), Obesity (body mass index [BMI] of 30 kg/m <sup>2</sup> or higher but < 40 kg/m <sup>2</sup> ), Overweight (BMI of 25 kg/m <sup>2</sup> or higher but < 30kg/m <sup>2</sup> ); 8.) Pregnant; 9.) Sickle cell disease or Thalassemia; 10.) Type 1 or 2 diabetes mellitus; 11.) Cerebrovascular disease (affects blood vessels and blood supply to the brain); 12.) Neurologic conditions including but not limited to Alzheimer's Disease or dementia; 13.) Liver disease; 14.) Current or former smoker; 15.) Substance use disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
12.	Are you 18 through 49 years old AND have one or more of the underlying medical conditions listed above, and are seeking a booster because the benefits outweigh the risks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
13.	Are you 18 through 64 years old AND are at increased risk for COVID-19 exposure and transmission because of occupational or institutional setting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
14.	Have you received 2 doses of the Pfizer vaccine, the second dose being at least 6 months ago?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of 2 <sup>nd</sup> dose: _____ (if applicable)
15.	Have you received a previous dose of Moderna or Janssen COVID-19 vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
16.	Have you received a previous dose of a COVID-19 vaccine authorized by the WHO but not by the FDA (AstraZeneca – VAXZEVRIA, Sinovac – CORONAVAC, Serum Institute of India – COVISHIELD, Sinopharm/BIBP)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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 undergone the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available is based on the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks. Please note: FDA approved the Pfizer-BioNTech COVID-19 vaccine as a two-dose series in individuals 16 years of age and older. The vaccine continues to be available under an EUA for certain populations, including for those individuals 12 through 15 years of age and for the administration of a third dose in the populations set forth in the consent section below.

### Consent

I have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if my vaccine requires two doses, I will need to be administered (given) two doses to be considered fully vaccinated. Further, I understand that a third dose of my vaccine ("booster") may be recommended for me to receive at least 6 months following the second dose of Pfizer-BioNTech COVID-19 vaccine if I am a member of a certain population (e.g., 65 years or older, a resident of a long term care facility, 50-64 years with an underlying medical condition, 18-49 years with an underlying medical condition based on individual benefits and risks, 18-64 years and at an increased risk for COVID-19 exposure and transmission because of occupational or institutional setting based on individual benefits and risks) to increase my protection.

I have had a chance 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 plan, Medicare 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.

Recipient/Surrogate/Guardian (Signature)      Date / Time      Print Name      Relationship to Patient  
 recipient      (if other than recipient)

Telephonic Interpreter's ID #      Date / Time  
**OR**

Signature: Interpreter      Date/ Time      Print: Interpreter's Name and Relationship to Patient

**Area Below to be Completed by Vaccinator**

Which vaccine is the patient receiving today?					
Vaccine Name	Administration			EUA Fact Sheet Date	Manufacturer & Lot #
Pfizer/BioNTech	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose	<input type="checkbox"/> Third Dose		
Moderna	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose			
Astra-Zeneca	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose			
Janssen	<input type="checkbox"/> Single Dose				

Administration Site     Left Deltoid       Right Deltoid       Left Thigh       Right Thigh  
 Dosage                     0.5 ml                     0.3 ml

I have provided the patient (and/or parent, guardian or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained.

Vaccinator Signature: \_\_\_\_\_

**\* Use of this form is optional.**

**Updated September 29, 2021**