



COVID-19 Immunization Screening and Consent Form*

Form with fields for Recipient Name, Preferred Name, DOB, Current Gender ID, Sex Assigned at Birth, Marital Status, Address, City, State, Zip, Email Address, Parent/Guardian/Surrogate, Phone, Preferred Language, Ethnicity, Race, 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

Table with 6 rows of screening questions and 4 columns for Yes/No/Unknown responses.

7.	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
8.	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
9.	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
10.	Have you received a previous dose of the COVID-19 vaccine? If yes, which vaccine?	<input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer		<input type="checkbox"/> No Date: _____ <small>(if applicable)</small>

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.

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 of this vaccine in order for it to be effective. 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) recipient	Date / Time	Print Name	Relationship to Patient (if other than recipient)
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Telephonic Interpreter's ID # OR	Date / Time
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Signature: Interpreter	Date/ Time	Print: Interpreter’s Name and Relationship to Patient
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Area Below to be Completed by Vaccinator			
Which vaccine is the patient receiving today?			
Vaccine Name	Administration		EUA Fact Sheet Date
Pfizer/ BioNTech	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second 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: _____