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

**Patient Information. Please Print Clearly.**

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| Patient Full Name  | Date of Birth |  Gender Male/ Female |
| Address | Phone Number | Email |
| Race: American Indian or Alaska Native Asian White Black or African American Pacific Islander Native American Other | Social Security Number | Driver’s License |

**Parent/Legal Guardian Information (If patient is under the age of 18). Please Print Clearly.**

**Primary Insurance Carrier ID #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grp #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Carrier ID #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grp #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Full Name | Date of Birth |  Gender Male/ Female |
| Address(if different from above) | Phone Number | Email |
| Race: American Indian or Alaska Native Asian White Black or African American Pacific Islander Native American Other | Relationship to Patient | Driver’s License |

COVID-19 Screening Questionnaire. Please circle YES or No for each question.

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| --- | --- | --- |
| **1.** Do you have today or have you had at any time in the last 10 days a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion, or runny nose, nausea, vomiting, or diarrhea? | YES | NO |
| **2.** Have you tested positive for and/or been diagnosed with Covid-19 within the last 10 days? | YES | NO |
| **3.** Have you had a severe allergic reaction (e.g. needed epinephrine or hospital care) to a previous dose of vaccine or to any of the ingredients of this vaccine? | YES | NO |
| **4.** Have you had any other vaccinations in the last 14 days (e.g. influenza vaccine, etc.)? | YES | NO |
| **5.** Have you had any Covid-19 Antibody therapy within the last 90 days (e.g. Regeneron, Bamlanivimab, COVID Convalescent Plasma, etc.)? | YES | NO |
| **6.** Do you carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies to reactions to any medications, foods, vaccines or latex? If so which\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | YES | NO |
| **7.** Are you immunocompromised or on a medication that affects your immune system? | YES | NO |
| **8.** Do you have a bleeding disorder or are you on a blood thinner. Blood-thinning medication? | YES | NO |
| **9.** For women, are you pregnant or is there a chance you could become pregnant? | YES | NO |
| **10.** For women, are you currently breastfeeding? | YES | NO |
| **11.** Are you under the age of 16? | YES | NO |

Immunization Screening

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| Is this the patient’s first or second dose of the COVID-19 vaccination? First Dose Second Dose |
| If this is your second dose, when was the date of your first dose?  |
| If this is your second dose, which vaccine did you receive (Pfizer, Moderna, etc.)? |
| If this is your second dose, did you experience any allergic reaction to the first dose? If so which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

* I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to Tristate Community Healthcare or its agents to administer the COVID-19 vaccine.
* I understand that this product has not been approved or licensed by the FDA, but has been authorized for emergency use by the FDA, under an EUA to prevent Coronavirus Disease 2019 for use in individuals 18 years of age or older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
* I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine that I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were/will be answered to my satisfaction.
* I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
* On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Tristate Community Healthcare, and their staff, agents, successors, divisions, affiliates, subsidiaries, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administrated of the vaccine listed above.
* I acknowledge that: (a) I understand the purposes/benefits of my personal immunization information that may be shared with the Centers for Disease Control (CDC) or other federal agencies.
* I further authorize Tristate Community Healthcare or its agents to submit a claim to my insurance or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if Tristate Community invoices me after the time of service, upon receipt of such invoice.
* I acknowledge receipt of the Notice of Privacy Rights.

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Patient/ Legal Guardian Signature Date

FOR ADMINISTRATIVE USE ONLY

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Manufacturer Name | Dose | EUA Fact Sheet Date | Date of Vaccination | Lot # | Exp. Date | Route | MA Initials |
|  | First Second |  |  |  |  | Left IMRight IM |  |