Community Health Connections
*We take great care of you!*

# COVID-19 Immunization Screening and Consent Form

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|---|---|
| **Recipient Name:** (Please Print) | **Date of Birth:** |
| **Address:** **City** **Zip Code** | **Phone Number:** |

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|---|---|---|---|
| **Housing Status:** □ Own/Rent □ Doubling up □ Homeless □ Transitional □ Shelter<br>**Public Housing /Section 8**: □ No □ Yes | **Gender:** □ Male □ Female □ Transgender □ Questioning □ Nonbinary/Genderqueer □ Decline to Answer | **Sexual Identity/Orientation:** □ Heterosexual/Straight □ Gay/Lesbian □ Decline □ Bisexual/Pansexual □ Something Else | **Race:** □ White □ Asian □ American Indian □ Other □ Black/African American □ Native Hawaiian/Pacific Islander □ Multiple Race □ Decline |

| | | |
|---|---|---|
| **Ethnicity**<br>□ Hispanic/Latinx □ Not Hispanic/Latino<br>□ Don't Know □ Decline | **Primary Care Provider:** | **Are you a Migrant Worker Status?**<br>□ No □ Migratory □ Seasonal<br>**Are you a Veteran?** □ Yes □ No |

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| **Primary Language:** | **Medical Insurance:** □ Mass Health □ Medicare □ Medicare & Medicaid □ No Insurance □ Health Safety Net (HSN) □ Private: _____ |
| **Country of Birth:** | **Plan ID Number:** |

| **Pre-Vaccination Screening** | **Yes** | **No** | **Don't Know** |
|---|---|---|---|
| 1. Are you feeling sick today? | □ | □ | □ |
| 2. Have you ever received a dose of COVID-19 vaccine? (Mark last vaccine dose received)<br>Primary Series: □ 1 dose □ 2 dose □ 3 dose □ Additional dose Boosters: □ 1st Booster<br>□ Pfizer □ Moderna □ Janssen (Johnson & Johnson) □ Other | □ | □ | |
| 3. **Have you ever had an allergic reaction to:**<br>(a severe reaction [i.e. anaphylaxis] that required treatment with epinephrine or EpiPen or that caused you to go to the hospital ***or*** an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing) | | | |
| - A component of a COVID-19 vaccine, including either of the following:<br>• 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? | □ | □ | □ |
| 4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (a severe reaction [i.e. anaphylaxis] that required treatment with epinephrine or EpiPen or that caused you to go to the hospital or an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing) | □ | □ | □ |

5. **Check all that apply to you:**

□ A female between ages 18 and 49 years old □ A male between ages 12 and 29 years' old
□ Had a severe allergic reaction to food, pet, venom, environmental or oral medication.
□ 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) or take immunosuppressive drugs or therapies
□ History of Guillain-Barré Syndrome (GBS)
□ Have a bleeding disorder
□ Take a blood thinner
□ Have a history of heparin-induced thrombocytopenia (HIT)
□ Currently pregnant or breastfeeding
□ Have received dermal fillers □ Have a history of myocarditis or pericarditis

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**Emergency Use Authorization**

The FDA has made COVID-19 vaccines 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. The FDA's decision to make COVID-19 vaccines available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

## Consent

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that (Pfizer/ Moderna) vaccines require multiple doses and boosters in order for it to be most effective. Janssen requires one dose and boosters to be most effective. I have been given an opportunity 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.

There is a remote chance that the vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting the injection. For this reason, you will be monitored after vaccination for 15 – 30 minutes depending upon past medical history.

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 insurance plan, Medicare, Medicaid 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.

_____

Signature of Recipient/Guardian Date

| **Area Below to be Completed by Vaccinator** | | | | | | |
|---|---|---|---|---|---|---|
| **Which vaccine is the patient receiving today?** | | | | | | |
| **Vaccine Name** | **Administration** | | | | **Fact Sheet** | **Lot Number & Expiration Date** |
| Pfizer (Comirnaty) | ☐ 1st Dose | ☐ 2nd Dose | ☐ Additional | ☐ Bivalent | 3/29/2022<br>8/31/2022 | |
| Pfizer-BioNTech 6mo – 4 years | ☐ 1st Dose | ☐ 2nd Dose | ☐ 3rd Dose | | 6/28/2022 | |
| Pfizer-BioNTech 5 years – 11 years | ☐ 1st Dose | ☐ 2nd Dose | ☐ Booster | ☐ Bivalent | 8/31/2022 | |
| Moderna (Spikevax) | ☐ 1st Dose | ☐ 2nd Dose | ☐ Additional | ☐ Bivalent (6 and older) | 3/29/2022<br>8/31/2022 | |
| Janssen (J&J) | ☐ Single Dose | | ☐ Additional | ☐ Booster | 1/31/2022 | |

**Administration Site** ☐ Left Deltoid ☐ Right Deltoid ☐ Left Thigh ☐ Right Thigh

**Dosage** ☐ 0.5 ml ☐ 0.3 ml ☐ 0.25 ml ☐ 0.20 ml

☒ I have reviewed side effects with patient (and parent, guardian or surrogate, as applicable)

☒ I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered correctly and to the best of my ability.

**Vaccinator Signature**: _____ **Date:** _____ rev 10/14/2022