Community Health Connections
We take great care of you!

COVID-19 Immunization Screening and Consent Form

Recipient Name **(please print)**			Social Security Number
Date of Birth	Gender	Email	
Address City State Zip			Phone Number
Parent/Guardian (if applicable, **please print**)			Preferred Language
Insurance Company and Number		Primary Care Physician Address/Phone Number **(IF NOT CHC)**	

Screening Questionnaire

1.	Are you feeling sick today?	☐ Yes	☐ No	
2.	In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	☐ Yes (Unable to vaccinate)	☐ No	☐ Unknown
3.	Have you been treated with antibody therapy for COVID-19 in the past 90 days (3 months)? *If yes, when did you receive the last dose?*	☐ Yes (Unable to vaccinate)	☐ No	☐ Unknown
4.	Have you ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing, to any vaccine or shot?	☐ Yes	☐ No	☐ Unknown
5.	Have you ever had an allergic reaction to any of the following; polyethylene glycol (PEG), dimyristyl glycerol (DMG), distearoyl-sn-glycero-3-phosphocholine (DSPC), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, sucrose? (found in some laxatives and colonoscopy preparations medications)	☐ Yes (Unable to vaccinate)	☐ No	☐ Unknown
6.	Have you had any vaccines in the past 14 days (2 weeks) including flu shot?	☐ Yes (Unable to vaccinate)	☐ No	☐ Unknown
7.	Are you pregnant or considering becoming pregnant? (Check with doctor)	☐ Yes	☐ No	☐ Unknown
8.	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	☐ Yes*	☐ No	☐ Unknown*
9.	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?	☐ Yes*	☐ No	☐ Unknown*
10.	Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes	☐ No	☐ Unknown
11.	Have you ever received a dose of COVID-19 vaccine? ☐ Moderna ☐ Pfizer ☐ J & J (Janssen) ☐ Astra-Zeneca ☐ Other	☐ Yes	☐ No	☐ Unknown

* **Provide written instructions from your doctor of complications for nursing to assess during post vaccination observation (Not needed for second vaccination or CHC patients)**

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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 completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine 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 if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be 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.

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 (Relationship to patient) Date

Area Below to be Completed by Vaccinator				
Which vaccine is the patient receiving today?				
Vaccine Name	**Administration**		**EUA Fact Sheet Date**	**Lot Number & Expiration Date**
Pfizer/ BioNTech	□ First Dose	□ Second Dose		
Moderna	□ First Dose	□ Second Dose	12/2020	
Astra-Zeneca	□ First Dose	□ Second Dose		
Janssen (J & J)	□ Single Dose			

Administration Site □ Left Deltoid □ Right Deltoid □ Left Thigh □ Right Thigh □ Nasal

Dosage □ 0.5 ml □ 0.25ml

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

X 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:** _____