COVID-19 VACCINE SCREENING & CONSENT FORM

Name: _____ Date of birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

Sex assigned at birth: ◯ Male ◯ Female Ethnicity: ◯ Hispanic ◯ Non-Hispanic

Race: ◯ Asian ◯ Black ◯ Native American ◯ Pacific Islander ◯ White ◯ Other: _____

If this is a two dose regiment, is this your first or second dose of the COVID-19 vaccination:

◯ First dose ◯ Second dose ◯ N/A

COVID SCREENING QUESTIONS:

Please select YES or NO for each question.

1. Do you have today or have you had 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?	◯ YES ◯ NO
2. Have you tested positive for and/or been diagnosed with COVID-19 infection within the last 10 days?	◯ YES ◯ NO
3. Have you had a severe allergic reaction (i.e. needed epinephrine or hospital care) to a previous dose of this vaccine or to any of the ingredients of this vaccine?	◯ YES ◯ NO
4. Have you had any other vaccinations in the last 14 days?	◯ YES ◯ NO
5. Have you had any COVID-19 Antibody therapy within the last 90 days (i.e. Regenron, Bamlanivimab, COVID Convalescent Plasma, etc.)?	◯ YES ◯ NO

IMMUNIZATION SCREENING QUESTIONS:

Please select YES or NO for each question.

1. Do you carry an Epi-Pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, food, vaccines or latex?	◯ YES ◯ NO
2. For women, are you pregnant or is there a chance you could become pregnant?	◯ YES ◯ NO
3. For women, are you currently breastfeeding?	◯ YES ◯ NO
4. Are you immunocompromised or on a medication that affects your immune system?	◯ YES ◯ NO
5. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?	◯ YES ◯ NO
6. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive?	◯ YES ◯ NO

This Section is for Office Use ONLY

Patient Name: _____

Pt DOB: _____

Pt ID#: _____

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Name: _____ Date of birth: _____

• 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) legally authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to CAN Community Health, Inc. to administer the COVID-19 vaccine.

• I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals either 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 I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were 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 CAN Community Health, Inc., the State Department of Health (DOH), and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, 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 administration of the vaccine listed above.

• I acknowledge that: (a) I understand the purposes/benefits of the state immunization registry and (b) CAN Community Health, Inc. will include my personal immunization information in the state immunization registry and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.

• I further authorize CAN Community Health, Inc. to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to CAN Community Health, Inc. with respect to the above requested items and services. I understand that I will not be charged a fee for the vaccine or its administration.

Signature of patient or authorized representative: _____ Date: _____
Name and relationship to person receiving the vaccine: _____

FOR CLINIC USE ONLY

Clinic site: _____ Site address: _____
EUA fact sheet provided: ◯ YES ◯ NO
Date vaccine administered: _____ Date booster required:_____
Vaccine manufacturer: _____ Lot number: _____
Expiration date: _____ Site of IM injection: ◯ RDT ◯ LDT
Name and title of vaccine administrator: _____
Signature of vaccine administrator: _____
Date: _____

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