Covid-19 vaccine 1st dose or 2nd dose

Covid-19 vaccine consent and screening 1st dose or 2nd dose

Name (Last)	(First)	**DOB**	**Gender**
Address		**Address 2**	
City	**State**	**Zip**	**Phone**
Race		**Ethnicity**	
SOCIAL		**MEDICARE**	
Primary Care Provider Name:		**Mother's Maiden Name:**	
Emergency Contact Name:	**Emergency Contact Relation:**	**Emergency Contact Phone:**	

Select which dose you are receiving (circle one): 1st Dose | 2nd Dose |

If applicable, which vaccine product did you receive last (circle one): Pfizer | Moderna | Janssen

Screening Questionnaire				
1.	Will you be under the age of 12 years old for the Pfizer vaccine, or under 18 years old for the Moderna vaccine, on the day of your appointment?	◻ Yes	◻ No	
2.	Are you feeling sick today?	◻ Yes	◻ No	
3.	In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a health care provider or health department to isolate orquarantine at home due to COVID-19 infection or exposure?	◻ Yes	◻ No ◻ Unknown	
4.	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past days (3 months)? *If yes, when did you receive the last dose?* Date: _ _ _ _	◻ Yes	◻ No ◻ Unknown	
5.	Have you ever had an immediate allergic reaction (e.g., hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injection, or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything?	◻ Yes	◻ No ◻ Unknown	
6.	Are you pregnant or considering becoming pregnant?	◻ Yes	◻ No ◻ Unknown	
8.	Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?	◻ Yes	◻ No	◻ Unkn
9.	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	◻ Yes	◻ No	◻ Unknown
10.	Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?	◻ Yes	◻ No	Date: ____ (if
11.	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	
12.	Have you received a previous dose or doses of a non-FDA authorized or approved COVID-19 vaccine (AstraZeneca – VAXZEVRIA, Sinovac – CORONAVAC, Serum Institute of India – COVISHIELD, Sinopharm/BIBP, COVAXIN)?	◻ Yes	◻ No	Date(s): ____ (if

Consent (check each box below after reading and signing)

- ☐ I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) FactSheet, a copy of which I was provided with this Consent Form. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent Form.
- ☐ I understand that at this time, some COVID-19 vaccines require 2 doses given 21-28 days apart dependent on the manufacturer. If this is my first dose of the COVID-19 vaccine and a second dose is required (Pfizer and Moderna only), I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the series.
- ☐ I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur.
- ☐ I understand that I will be receiving the vaccination at no cost to me.

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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 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. Please note: FDA approved the Pfizer-BioNTech COVID-19 vaccine as a two-dose series in individuals 16 years of age and older. The vaccine continues to be available under an EUA for certain populations, including for those individuals 5 through 15 years of age and for the administration of a third dose in the populations set forth in the consent section below.

Emergency Use Instruction
Emergency Use Instructions (EUIs) are issued by the CDC to provide information about emergency use of FDA-approved medical products that may not be included in or differ in some way from the information provided in the FDA-approved labeling (package insert). The COVID-19 vaccine by Pfizer-BioNTech is an FDA-approved COVID-19 vaccine (brand name Comirnaty, mRNA) to prevent COVID-19 in persons 16 years of age and older. CDC is issuing EUI to provide information about use of this vaccine as an additional primary dose in certain immunocompromised persons (12 years of age and older) and a booster dose in certain adults (18 years of age and older) who received certain **non-FDA authorized or approved COVID-19 vaccine** (e.g., certain vaccines available outside of the United States or from clinical trial participation).

Select One of the Following:

- ☐ If INSURED, check this box attesting to bringing in your **prescription and medical insurance cards** for your vaccine appointment. By selecting this, you are also authorizing the pharmacy to bill your insurance on your behalf for the immunization – understanding you will not incur any costs.
- ☐ If UNINSURED, you must check this box to attest that the following information is true and accurate: I do not have any insurance, including but not limited to, Medicare, Medicaid, or any other private or government-funded benefit plan.

For uninsured patients, please select one of the following that you will present at the pharmacy. *This is needed, but not required, to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program.*

- ☐ Social Security Number
- ☐ State identification number & state of issuance
- ☐ Driver's license number & state of issuance

Pharmacy Use for Insurance Information

Signature of Person to Receive Vaccine & EUA /VIS (or Signature of Parent/Guardian if Patient is < 18 years old)

Signature:________________________________ **Date:** ___________________

Vaccine	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	EUA FACT SHEET DATE	Name of Vaccine Administrator
COVID-19	☐ 1st Dose	☐ IM - L Arm ☐ IM - R Arm		☐ Moderna ☐ Pfizer ☐ Janssen ☐ **Pfizer-pediatric (0.2 ml)**				
COVID-19	☐ 2nd Dose	☐ IM - L Arm ☐ IM - R Arm		☐ Moderna ☐ Pfizer ☐ **Pfizer-pediatric (0.2 ml)**				

Pharmacist Name who reviewed this form:________________ **Pharmacist Signature**: __________________

If certified vaccinator is different than the pharmacist who reviewed the form:

Name: ___________________________ Title: _________________ **Signature**: _________________________