COVID-19 BOOSTER DOSE

COVID-19 Immunization Screening and Consent Form

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): | Booster 1 | Booster 2

Select the completed primary COVID-19 Vaccine series:

Pfizer-BioNTech Moderna Janssen

Dates of primary COVID-19 Vaccination: 1st Dose: __

1st Dose: ___/___/_____ 2nd Dose: ___/___/______ Booster Dose: ___/___/_____

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Screening Questionnaire				
1.	Are you feeling sick today?	□ Yes	□ No	
2.	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 or quarantine at home due to COVID-19 infection or exposure?	□ Yes	□ No	□ Unknown
3.	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90? days (3 months)? *If yes, when did you receive the last dose?* Date: ________________	□ Yes	□ No	□ Unknown
4.	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
5.	Are you pregnant or considering becoming pregnant?	□ Yes	□ No	□ Unknown
6.	Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?	□ Yes	□ No	□ Unknown
7.	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
8.	Are you moderately or severely immunocompromised due to one or more of the medical conditions or receipt of immunosuppressive medications or treatments listed below? 1) Active treatment for solid tumor and hematologic malignancies, 2) Receipt of solid-organ transplant and taking immunosuppressive therapy, 3) Receipt of CAR-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy), 4) Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome), 5) Advanced or untreated HIV infection, 6) Active treatment with high-dose corticosteroids (i.e., 8805;20mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory	□ Yes	□ No	□ Unknown

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9.	Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?	□ Yes	□ No	□ Unknown
10.	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	□ Yes	□ No	□ Unknown
11.	Have you had Guillain-Barre Syndrome after receipt of the Janssen vaccine?	□ Yes	□ No	□ Unknown
12.	Do you have a history of MIS-C or MIS-A (multisystem inflammatory syndrome in children or multisystem inflammatory syndrome in adults)?	□ Yes	□ No	□ Unknown
13.	Are you 12 years old or older, and have you received 2 doses of the Pfizer vaccine, the second dose being at least 5 months ago?	□ Yes	□ No	Date: (if applicable)
14.	Have you received 2 doses of the Moderna vaccine, the second dose being at least 5 months ago?	□ Yes	□ No	Date(s): (if applicable)
15*	Have you received a previous dose of the Janssen vaccine, at least 2 months ago?	□ Yes	□ No	Date: (if applicable)
16*	If you had a previous dose of Janssen (Johnson & Johnson), did you develop thrombosis with thrombocytopenia syndrome (TTS)?	□ Yes	□ No	□ Unknown
17*	Are you 50 years old or older, and have you received 3 doses of the Pfizer or Moderna vaccine, the third dose being at least 4 months ago?	□ Yes	□ No	Date: (if applicable)
18*	Have you received 2 doses of the Janssen (Johnson & Johnson) vaccine, or 1 dose of the Janssen vaccine and 1 dose of mRNA vaccine, the second dose being at least 4 months ago?	□ Yes	□ No	Date: If applicable)
19.	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, Novavax – Covovax or Nuvaxovid)?1	□ Yes	□ No	□ Unknown

***Questions #13 - 15 pertain to the first booster dose eligibility.**
****Questions #17 and 18 pertain to the second booster dose eligibility.**

1 As set forth in the CDC's Emergency Use Instructions (EUI) , a non-FDA authorized or approved COVID-19 vaccine such as those vaccines "listed for emergency use by the World Health Organization, or is included in CDC's Technical Instructions for Implementing Presidential Proclamation Advancing Safe Resumption of Global Travel During the COVID- 19 Pandemic and CDC's Order, or that is a non-placebo part of a clinical trial within or outside the United States that is a WHO-EUL COVID-19 vaccine or a vaccine that is not listed for emergency use by WHO but for which a U.S. data and safety monitoring board or equivalent has independently confirmed efficacy in the United States (hereinafter '"non-FDA authorized or approved COVID-19 vaccines').

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).

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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.

By signing this form, I attest that all information I have provided on this form is true and accurate, thereby qualifying me to receive a COVID-19 vaccine booster dose.

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Recipient/Surrogate/Guardian (Signature) Date Print Name Relationship to Patient(if other than recipient)

****PHARMACY USE ONLY****

Area Below to be Completed by Vaccinator						
Which vaccine is the patient receiving today?						
Vaccine Name	**Administration**				**EUA Fact Sheet Date**	**Manufacturer & Lot #**
Pfizer/BioNTech	□ First Dose	□ Second Dose	□ First Booster Dose	□ Second Booster Dose		
Moderna	□ First Dose	□ Second Dose	□ First Booster Dose	□ Second Booster Dose		
Janssen	□ Single Dose	□ First Booster Dose	□ Second Booster Dose	N/A		

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

Dosage □ 0.5 ml □ 0.3 ml □ 0.25 ml

Reason for additional or booster dose (if applicable): ______________________________________

Pharmacist Name who reviewed this form:______________________**Pharmacist signature:**______________

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

Name: ______________________________________**Signature:**______________________