COVID-19 Vaccine Screening & Consent Form

First Name: ______________________ **Last Name:** _________________________ **DOB:** _________ MM/DD/YYYY **AGE:** ___ **GENDER:** _____

Race: ☐White ☐Black ☐Asian ☐Pacific Islander ☐Native American ☐Other **Ethnicity:** ☐Hispanic/Latino ☐ Not Hispanic/Latino

Phone: (____)_____________ **Address:** __________________________________ **City:** ________________ **Zip:** ________

Rx BIN: ___________ **Rx PCN:** _____________ **Rx Group:** ___________________ **Member ID:** ____________________________

Medicare Beneficiary ID Number (from Red, White and Blue Card) Applies to all individuals age 65+ even if you have an "Advantage Plan"	
Social Security Number (full number required – if you do not have SSN, please see a staff member):	
Mother's Maiden Last Name (Required for Immunization Record)	

Primary Care Physician: ________________________________ **PCP Phone Number:** (____)_____________

Please circle **YES** or **NO** for the following questions **and** answer **ALL** questions.

Are you feeling sick today?	**YES**	**NO**
Have you received a dose of COVID-19 vaccine? **If yes, which vaccine product did you receive?** ☐ **Pfizer** Date of administration: _______________ Any side effects: ____________________________ ☐ **Moderna** Date of administration: _______________ Any side effects: ____________________________	**YES**	**NO**
Are you allergic to polyethylene glycol (this is found in products such as cosmetics, skin care products, cough syrups, laxatives, bowel preps for colonoscopies, some food and drinks)	**YES**	**NO**
Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital? **If yes, explain:**	**YES**	**NO**
Do you have a severe bleeding disorder or are you taking a blood thinner?	**YES**	**NO**
Have you tested positive for COVID-19? **If yes, date of positive lab result:**	**YES**	**NO**
Have you received passive antibody therapy as a treatment for COVID-19? **If yes, when:**	**YES**	**NO**
Are you immunosuppressed?	**YES**	**NO**
Are you pregnant or planning to become pregnant?	**YES**	**NO**
Are you breastfeeding?	**YES**	**NO**
Have you ever felt faint or fainted after receiving a vaccine or medical procedure?	**YES**	**NO**
Have you received a vaccination within the last 14 days?	**YES**	**NO**

I have received, read, and understand the "Fact Sheet for Recipients and Caregivers" about the "Emergency Use Authorization (EUA) for the COVID-19 vaccine. I understand the benefits and risks of receiving this COVID-19 vaccine. I have had an opportunity to ask questions which were answered to my satisfaction. I hereby provide informed consent that the vaccine indicated below be given to me or to the person named above for whom I am authorized to make this request. Immunization given today will be enter into CAIR and share unless I object.

Parent/Guardian's Signature: ________________________________ ____________________ Date: ____________________
Relationship to person above

For Official Use	Date	Vaccine / Mfg		Lot # & Exp. Date		Administered By	IM Site
		COVID-19 Vaccine	☐ Moderna. ☐ Janssen ☐ Pfizer				**LD RD**