

COVID-19 VACCINE SCREENING AND CONSENT FORM

COVID-19 Vaccine

SECTION 1: INFORMATION ABOUT YOU (PLEASE PRINT)

Name: Last: _____ First: _____ Middle Initial: _____		
Date of Birth: _____		Mobile Phone Number (Patient or Guardian): () _____
Address: _____		Apt/Room #: _____
City: _____	State: _____	Zip: _____
Email: _____		
Sex (Gender assigned at birth) <input type="checkbox"/> Female <input type="checkbox"/> Male	Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other <input type="checkbox"/> Other Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other Nonwhite <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Other Pacific Islander	Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Primary Insurance Carrier ID #: _____ Grp #: _____ Insurance Company : _____ Insurance Company Phone # _____ Insured's Name: _____ Relationship: _____ Insured's Date of Birth _____ Secondary Insurance Carrier ID #: _____ Grp #: _____ Insurance Company : _____ Insurance Company Phone # _____ Insured's Name: _____ Relationship: _____ Insured's Date of Birth _____		
Is this the patient's first or second dose of the COVID-19 vaccination? <input type="checkbox"/> First Dose <input type="checkbox"/> Second Dose		

SECTION 2: COVID-19 SCREENING QUESTIONS

Please check YES or No for each question.	Yes	No
1. Are you sick today?		
2. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
3. Do you carry an Epi-pen for emergency treatment of anaphylaxis?		
4. For women, are you pregnant or is there a chance you could become pregnant or are you breastfeeding?		
5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?		
6. Have you had any other vaccinations in the previous 14 days?		
7. In the past two weeks, have you tested positive for COVID-19?		
8. Have you had in the last 10 days 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, nausea, vomiting, or diarrhea?		

SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE

Please check YES or No for each question.	Yes	No
9. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) <ul style="list-style-type: none"> • A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures • Polysorbate • A previous dose of COVID-19 Vaccine • Another vaccine (other than COVID-19 vaccine) or an injectable medication • Something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies. 		
10. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?		
11. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
12. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive:		

- 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) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Florida Department of Health (DOH) or its agents 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 18 years of age and 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 understand that this is a two-dose series vaccine. If given a first dose of the Moderna vaccine, I will need to receive the 2nd dose of the Moderna vaccine at 28 days from the first dose. If given a first dose of the Pfizer vaccine, I will need to receive the 2nd dose the Pfizer vaccine at 21 days from the first dose.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes 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 the State of Florida, the Florida 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 Florida SHOTS, Florida's immunization registry and (b) DOH will include my personal immunization information in Florida SHOTS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize DOH or its agents 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 DOH or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if DOH invoices me after the time of service, upon receipt of such invoice.
- I acknowledge receipt of the Notice of Privacy Rights.

Signature of Patient or Authorized Representative _____ **Date:** _____

Print Name of Representative and Relationship to Person Receiving Vaccine: _____

Site (LD/RD)	Route	Manufacturer (MVX)	Lot # Unit of Use/ Unit of Sale	Expiration Date	Date of EUA Fact Sheet
	IM				

Administered at location: facility name/ID	
Administered at location: Type	
Administration Address:	

Vaccinator Print Name: _____ **Signature:** _____ **Date:** _____

Vaccine administering providersuffix: _____