Franklin County Public Health Services

Mother’s Maiden Name:

First:

Last:



**COVID-19 Immunization Screening and Consent Form\***

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| --- | --- |
| Recipient Name (please print) | Preferred Name |
| DOB | Current Gender ID **Key:**W – Woman/Girl TW – Transgender Woman/Girl M – Man/BoyClick here to choose TM – Transgender Man/Boy NB – Non-Binary Person GNC – Gender Non-Conforming Q – Not Sure/Questioning NR – Chose not to RespondGNL - Gender not Listed (write-in) \* Gender Pronouns: write-in by client’s name |
| Sex Assigned at Birth **Key:**Click here to choose M – Male F – FemaleI – Intersex NR – Chose not to RespondSNL – Sexual Orientation not Listed (write-in) | Marital Status **Key:**Click here to choose S – Single D – Divorced M – MarriedW – Widowed V – Civil Union U – UnknownSEPARATED – Legally Separated PARTNER – Life Partner |
| Address City State Zip | Email Address |
| Parent/Guardian/ Surrogate (if applicable, please print) | Phone | Preferred Language |
| Ethnicity **Ethnicity Key:**Click here to choose DECL – DeclinedHIS – HispanicOrigin NHL – Non-HispanicOrigin UNK - Unknown | Race **Race Key:**Click here to choose AIA – Native American or Alaskan ASN – AsianBAA – African American or Black DECL – Declined NHP – Native Hawaiian or Pacific IslanderWHT – White OTH – Other or Multiracial |
| Primary InsuranceName | Primary Insurance ID# | Subscriber Name/DOB | Subscriber Relation to Patient |
| Primary Insurance Address | Primary Insurance Group # | Primary Insurance Phone # |
| Secondary InsuranceName | Secondary Insurance ID# | Subscriber Name/DOB | Subscriber Relation to Patient |
| Secondary Insurance Address | Secondary Insurance Group # | Secondary Insurance Phone # |
| Clinic/Office Site Where Vaccine is Administered | Primary Care Physician Address/Phone Number |
|  | **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 has 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, exposure or travel? | □ 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?* | □ Yes | □ No | □ Unknown |
| 4. | Have you ever had an immediate allergic reaction, such as hives, facial swelling, difficulty breathing or 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. | Have you had any vaccines in the past 14 days (2 weeks) including flu shot?*If yes, how long ago was your most recent vaccine?* Date:  | □ Yes | □ No | □ Unknown |
| 6. | Are you pregnant or considering becoming pregnant? | □ Yes | □ No | □ Unknown |
| 7. | Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or anyother condition that weakens the immune system? | □ Yes | □ No | □ Unknown |
| 8. | 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 |
| 9. | Do you have a bleeding disorder or are you taking a blood thinner? | □ Yes | □ No | □ Unknown |
| 10 | Have you received a previous dose of COVID-19 vaccine?*If yes, ☐ Moderna ☐ Pfizer ☐ Janssen Date:\_\_\_\_\_\_\_\_\_\_\_* | □ Yes | □ No |  |

**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.

# Consent

I have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if my vaccine requires two doses, I will need to be administered (given) two doses of this vaccine in order for it to be effective. I have had a chance to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health plan, Medicare or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

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

Telephonic Interpreter’s ID # Date / Time

**OR**

Signature: Interpreter Date/ Time Print: Interpreter’s Name and Relationship to Patient

|  |
| --- |
| Area Below to be Completed by Vaccinator |
| **Which vaccine is the patient receiving today?** |
| Vaccine Name | Administration | EUA Fact Sheet Date | Manufacturer & Lot Number |
| Pfizer/ BioNTech | □ First Dose | □ Second Dose |  |  |
| Moderna | □ First Dose | □ Second Dose |  |  |
| Astra-Zeneca | □ First Dose | □ Second Dose |  |  |
| Janssen | □ Single Dose |  |  |  |
| Administration Site | □ Left Deltoid | □ Right Deltoid | □ Left ThighRoute □ IM | □ Right Thigh |
| Dosage | □ 0.5 ml | □ 0.3 ml  |   |  |
| □ I have provided the patient (and/or parent, guardian or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained. |
| Vaccinator Signature:  |  |