COVID-19 Vaccination Screening & Consent Form

Section 1: PERSONAL INFORMATION

Last Name: ___________________________ First Name: ___________________________ DOB: ___________________________ (mm/dd/yyyy)

Address: ___________________________ City: ___________________________ State: ___________________________ Zip Code: ___________________________ Phone: ___________________________

Sex:  □ Male  □ Female

Race:  □ American Indian or Alaska Native  □ Native Hawaiian or Other Pacific Islander  □ Asian  □ White  □ Black or African American  □ Unknown

Ethnicity:  □ Hispanic or Latino  □ Not Hispanic or Latino  □ Unknown

Currently, CDC is recommending that moderately to severely immunocompromised people receive an additional dose. This includes people who have:

- Been receiving active cancer treatment for tumors or cancers of the blood
- Received an organ transplant and are taking medicine to suppress the immune system
- Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system
- Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
- Advanced or untreated HIV infection
- Active treatment with high-dose corticosteroids or other drugs that may suppress your immune response

* By signing below, I attest that I am eligible for a booster vaccine for one of the recommended conditions above.

Signature: __________________________________________ Date: ___________________________

Section 2: CONSENT TO RECEIVE THE COVID-19 VACCINE (please INITIAL consent, agreement & understanding):

Vaccine Consent: I have been given a copy and have read, or have had explained to me, the information in the FACT SHEET FOR RECEPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA) regarding the vaccine that I receive. I request that the COVID-19 vaccination be given to me.

Financial Agreement: I acknowledge that an administration fee may be billed to my insurance carrier, third-party payers, Medicare or Medicaid for this service. I authorize the release of any medical or other information necessary to process this claim.

Privacy: I acknowledge that a copy of the Notice of Privacy Practices has been made available to me. We may disclose your vaccination information from this visit for public health purposes.

I understand that I must remain in the observation area for 15 minutes post vaccination if I do not have a history of allergic reaction or 30 minutes if I have a history of severe allergic reaction.

Section 3: PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS:

1. Are you feeling sick today?  □ Yes  □ No  □ Don't Know

2. Have you ever received a COVID-19 vaccine?  □ Yes  □ No  □ Don't Know
   - If yes, which vaccine product did you receive?
     □ Pfizer □ Moderna □ Jansen (J& J) □ Another product ___________________________

3. 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.)
   □ Yes  □ No  □ Don't Know  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.
   □ Yes  □ No  □ Don't Know  Polysorbate
   □ Yes  □ No  □ Don't Know  A previous dose of COVID-19 vaccine

4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?
   (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.)
   □ Yes  □ No  □ Don't Know

5. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any other vaccine or injectable medication? This would include food, pets, environmental, or oral medication allergies.
   □ Yes  □ No  □ Don't know

Revised: August 16, 2021
6. Check all that apply to you
☐ Am a female between ages 18 and 49 years old
☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies.
☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
☐ Have a weakened immune system (i.e., HIV infection, cancer)
☐ Take immunosuppressive drugs or therapies
☐ Have a bleeding disorder
☐ Take a blood thinner
☐ Have a history of herparin-induced thrombocytopenia (HIT)
☐ Am currently pregnant or breastfeeding
☐ Have received dermal fillers

By checking this box, the individual providing the information confirms the above information is accurate and that they meet the policy requirements for age in their state/jurisdiction. The individual authorizes the administration of the COVID-19 vaccine to themselves or the person named above for whom they are the parent/representative/guardian. They have received the EUA Fact Sheet(s) for COVID-19 vaccine(s). They acknowledge that they have received a copy of the Privacy Policy Terms and Conditions.

Patient Signature: __________________________________________ Date: __________________________

Parent/Guardian Signature: __________________________________ Date: __________________________

FOR CLINIC USE ONLY:

Vaccine Administration Reporting Information

Based on the recipient’s current condition and medical history, should the COVID-19 vaccine be administered?
☐ Yes  ☐ No

CVX (Product): 208 (SARS-COV-2, mRNA, spike protein) Lot Number (Unit of Use (UOU) or Unit of Sale (UoS): __________

Dose #: 3rd MVX (Manufacturer): PFR (Pfizer) Dose: .3 ml

Route: IM Date Administered: __________ Time Administered: AM/PM

Site: ☐ Right Deltoid  ☐ Left Deltoid

Administered By (Please print): __________________________ Last Name: __________________________ First Name: __________________________

Signature: __________________________ Facility & Address: Hilo Medical Center 1190 Wainuenue Ave. Hilo, HI 96720

Ordering Physician: Kathleen Katt, MD Signature: __________________________ See standing orders dated 12/16/2020

FOR CLINIC RECEPTION USE ONLY (Verbal Authorization for Minor): Staff Initials: __________________________

Patient Confirmed: ☐ Yes  Name: __________________________ Relationship: __________________________