FOR CLINIC USE ONLY:
☐ 3rd Booster Vaccine

COVID-19
Preventing Infection | Protecting Patients & Staff

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 ☐ Female ☐ Male	**Race** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American	☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ 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):

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

_____ (Initials) **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.

_____ (Initials) **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.

_____ (Initials) 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

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: _____

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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:_____