COVID Immunization Consent Form

Patient Name:_____ **Date of Birth:** _____ **Age**: _____ **Gender: Male / Female**

Street Address:_____**City:**_____**State:**_____**Zip Code:** _____

Email Address:_____**@**_____**Phone Number:**_____**SSN:**_____

Medicare/Medicaid/Ins ID#:_____**Drivers License #:**_____**Drug Allergies:**_____

Race: ☐White ☐Hispanic/Latino ☐Black/African American ☐Native American /Alaska Native ☐Asian ☐Native Hawaiian/Other Pacific Islander ☐Other

Complete the following questions for the individual receiving the vaccine. If you answer "YES" you may not be able to receive the COVID-19 vaccine.

Secton 1: **If YES and further guidance is needed, refer to Pfizer website at www.PfizerMedInfo.com or call 1-800-438-1985 for vaccine information on vaccine temperature excursions, efficacy, safety, stability, dosage, vaccine ingredients, mechanism of action and administration. For overview for Vaccination Providers about Moderna COVID-19 vaccine refer to* www.modernatx.com *or call 1-866-MODERNA.*	***YES**	**NO**
Have you had a previous COVID-19 vaccine? If yes, date?		
Have you ever had an allergic reaction to a COVID-19 vaccine or a COVID-19 vaccine component (including polyethylene glycol [PEG], which is found in some medications, or laxatives, and preparations for colonoscopy; or polysorbate, which is found in some vaccines, coated tablets, or IV steroids)?		
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?		
Have you ever had an immediate allergic reaction of any severity to any vaccine or injectable therapy? This would include an anaphylactic reaction that required treatment with epinephrine (or EpiPen) or treatment at a hospital, as well as an allergic reaction that occurred within 4 hours, such as difficulty breathing, hives, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness, and weakness.		
Did you develop myocarditis or pericarditis after the first dose of COVID-19 vaccine? Do you have history of myocarditis or pericarditis prior to COVID-19 vaccination? Are you a male between age 12 through 29 years?		
Are you pregnant, breastfeeding, planning to become pregnant? Women in this group may receive any FDA-authorized COVID-19 vaccine. Women 18 through 49 years of age can receive any FDA-authorized COVID-19 vaccine and should be informed of the increased risk of thrombosis with thrombocytopenia syndrome (TTS) after receiving Janssen COVID-19 Vaccine and the availability of other (mRNA)COVID-19 vaccines		
Are you immunocompromised? Do you have a condition that weakens your immune system? Are you receiving any immunosuppressive therapy? You are still eligible to receive Pfizer-BioNTech, Moderna, or Janssen COVID-19 vaccine unless you have a contraindication for some other reason. However, you will need special counseling about the vaccine.		
Have you had history of heparin-induced thrombocytopenia? If it has been 90 days or less since illness resolved, you may receive Pfizer-BioNTech or Moderna COVID-19 vaccine. After 90 days since illness resolved, you may be vaccinated with any FDA-authorized COVID-19 vaccine.		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Have you had Multisystem Inflammatory Syndrome (MIS)? Pfizer-BioNTech, Moderna, or Janssen COVID-19 vaccination should be deferred for at least 90 days to avoid interference with vaccine-induced immune responses.		

NOTE: Recipients of Janssen COVID-19 vaccine should be instructed to seek immediate medical attention if they develop shortness of breath, chest pain, leg pain or swelling, persistent abdominal pain, neurological symptoms (including severe or persistent headaches or blurred vision), nausea , vomiting, petechiae, or easy bleeding beyond the site of vaccination within 4 to 30 days of receipt of Janssen vaccine. Most people who have developed blood clots and low platelets were females ages 18 through 49 years.

NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine may be due in 21 days or 28 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your vaccination provider, PCP, or your ADH Local Health Unit in 21 days or 28 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date.Janssen COVID-19 vaccine is a ONE dose series.

Section 2: RELEASE AND ASSIGNMENT:

- **I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient Emergency Use Authorization Fact Sheet for each vaccine visit the website www.cvdvaccine.com: or you may also visit the Local Health Unit or private provider to receive a printed copy of the EUA Fact Sheet. To read the Vaccine Recipient Emergency Use Authorization for Moderna COVID-19 vaccinevisit the website** https://www.fda.gov/media/144638/download or (modernatx.com)
- **I give consent to this COVID-19 provider/staff for the individual named below to be vaccinated with COVID-19 vaccine.**
- **I hereby acknowledge that I have reviewed a copy of the Provider's Privacy Notice.**
- **I understand that information about this COVID-19 vaccination will be included in (WebIZ) Arkansas Immunization Information System.**

THE PHARMACY AT BROOKLAND

To My Insurance Carrier(s):

- **I authorize the release of any medical information necessary to process my insurance claim(s).**
- **I authorize and request payment of medical benefits directly to this COVID-19 Provider.**
- **I agree that the authorization will cover all medical services rendered until I revoke the authorization.**
- **I agree that the photocopy of this form may be used instead of the original.**

*My signature below indicates I have read, understand and agree to section **2. Release and Assignment** of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).*

Signature of patient or guardian: _____ **Date:**_____

Below is for pharmacy documentation

Ultra-cold COVID-19 Vaccine ☐Pfizer-BioNTech	**Frozen COVID-Vaccine** ☐Moderna		**Refrigerated COVID-19 Vaccine** ☐AstraZeneca ☐Janssen (Johnson & Johnson) ☐Novavax-Matrix-M1 ☐Other COVID-19 Vaccine _____		
Route: IM	**Site Code:**	**Dosage mL:**	**Manufacturer Code:**	**Lot Number:**	**Expiration Date:**

MFG Codes: PFR=Pfizer, MOD=Moderna, ASZ=AstraZeneca, JSN=Janssen, NVX=Novavax, MSD=Merck

Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA

Signature & Title of Vaccine Administrator: _____ **Administration Date:**_____