# COVID-19 Immunization Screening and Consent Form- ***First Dose***

| **Recipient Name:** | | **Preferred Name:** | |
|---|---|---|---|
| **DOB:** | **Legal Gender:** | **Gender ID:** | **Marital Status:** |
| **Address:** | | | **Email Address:** |
| **Parent/ Guardian/ Surrogate (if applicable, please print):** | | **Phone:** | **Preferred Language:** |
| **Ethnicity:**<br>☐ Not Hispanic or Latino ☐ Hispanic or Latino<br>☐ Prefer not to answer | | **Race: (Check all that apply)**<br>☐ White ☐ Alaska Native<br>☐ Asian ☐ Black or African American<br>☐ Native Hawaiian ☐ Other Pacific Islander<br>☐ American Indian ☐ Prefer not to answer | |
| **Clinic/ Office Site Where Vaccine is Administered:** | | **Primary Care Physician Address/ Phone Number:** | |

| **Primary Medical Insurance- *Please provide a Copy of Insurance Card*** | |
|---|---|
| ☐ I **HAVE** Medical Insurance | ☐ I **DO NOT HAVE** Medical Insurance- I would like a Sliding Fee Application. |
| **Insurance Company Name:** | **Billing address of Insurance Company:** |
| **Medical Policy#:** | |
| **Policy Holder's Name:** | **Policy Holder's SS#:** |
| | **Policy Holder's DOB:** |

## Screening Questionnaire (First Dose)

**Allergies:**______________________________________________

**Date of First Dose:**____________________

| | | | | |
|---|---|---|---|---|
| 1. | **Current Age:**___________ | | | |
| 2. | Are you feeling sick today? | ☐ Yes | ☐ No | ☐ Unknown |
| 3. | In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure? | ☐ Yes | ☐ No | ☐ Unknown |
| 4. | Have you been treated with antibody therapy for COVID-19 in the past 90 days (3 months)? | ☐ Yes | ☐ No | ☐ Unknown |
| 4a. | If yes, when did you receive the last dose? | **Date:**___________ | | |
| 5. | Have you ever had a serious or life- threatening allergic reaction, such as hives or difficulty breathing, to any vaccine or shot? | ☐ Yes | ☐ No | ☐ Unknown |
| 5a. | If yes, I understand and agree to wait 30 minutes after I receive my vaccination to be observed for adverse reaction. | ☐ Yes | ☐ No | **Initials:**____ |
| 5b. | If no, I understand and agree to wait 15 minutes after I receive my vaccination to be observed for adverse reaction. | ☐ Yes | ☐ No | **Initials:**____ |
| 6. | Have you had any vaccines in the past 14 days (2 weeks) including flu shot? | ☐ Yes | ☐ No | ☐ Unknown |
| 6a. | If yes, how long ago was your most recent vaccine? | **Date:**___________ | | |
| 7. | Are you pregnant or considering becoming pregnant? | ☐ Yes | ☐ No | ☐ Unknown |
| 8. | Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other conditions that weaken the immune system? | ☐ Yes | ☐ No | ☐ Unknown |
| 9. | 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 |

**Patient Bill of Rights:** ***Would you like a copy of the Patient Bill of Rights?***

☐ Yes, and a copy has been provided to me

☐ No, But I have been offered printed information and I had the opportunity to ask questions

**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. The vaccine has not completed the same type of review as an FDA - approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

**Consent:**

- I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination.
- I understand that this vaccine requires two doses and two doses of this vaccine will need to be administered (given) in order for it to be effective.

- I have been given an opportunity 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 out of pocket cost to me for this vaccine. I authorize Tri-County Family Medicine and its representatives to release any information they obtain, including medical information to my insurance company or their representatives to process claims for payment, As applicable, I authorize my insurance provider to pay Tri-County Family Medicine for the administration of the COVID-19 vaccine.
- I authorize release of all information needed (including but not limited to medical records) as needed for public health purposes, including reporting to applicable vaccine registries.

**Privacy Notice:**
I have been given the opportunity to review or receive a copy of Tri-County Family Medicine's (TCFM) Notice of Privacy Practices which describes how TCFM may use and disclose my protected health information following applicable State and Federal Laws.

**Consent to Contact:**
By giving Tri-County Family Medicine my phone number and email address, I agree to receive automated phone calls, text messages, and/or emails related to my COVID-19 vaccination.

**By signing below I acknowledge that I have reviewed the Emergency Use Authorization, Consent for Vaccination, Privacy Notice, Patient Bill of Rights and Consent to Contact. I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction.**

***Tri-County Family Medicine is scheduling the Covid-19 vaccination for the 2nd dose at the completion of the 1st dose visit. Should Tri-County Family Medicine not receive a supply of the Covid-19 vaccine for 2nd doses, the 2nd dose may be postponed.***

______________________________________________________________________

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

______________________________________________________________________

| Signature: Interpreter | Date/Time | Print: Interpreter's Name and Relationship to patient |
|---|---|---|

| **First Dose-** ***Area Below to be Completed by Vaccinator*** | | | | |
|---|---|---|---|---|
| *Vaccine Name* | | | | |
| ***Pfizer*** | | | | |
| ***Administration Site*** | ☐ Left Deltoid | ☐ Right Deltoid | ☐ Left Thigh | ☐ Right Thigh |
| ***Dosage*** | ☐ 0.5 ml | | | |
| ***Completed Observation Period:*** | ☐ **15 Minutes- Initials:_________** | | ☐ **30 Minutes- Initials:_________** | |
| ☐ I have reviewed side effects with patient (and parent, guardian or surrogate, as applicable) | | | | |
| ☐ I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered to the best of my ability. | | | | |
| **First Dose Vaccinator Signature:**_______________________________ | | | | |