Recipient Name (please print)	Preferred Name

DOB	Legal Gender	Gender ID	Marital Status	**Marital Status Key:** S – Single D – Divorced M – Married W – Widowed V – Civil Union U – Unknown SEPARATED – Legally Separated PARTNER – Life Partner

Address City State Zip	Email Address

Parent/Guardian/ Surrogate (if applicable, please print)	Phone	Preferred Language

Ethnicity	**Ethnicity Key:** DECL – Declined HIS – Hispanic Origin NHL – Non-Hispanic Origin UNK - Unknown	Race	**Race Key:** AIA – Native American or Alaskan ASN – Asian BAA – African Americanor Black DECL – Declined NHP – Native Hawaiian or Pacific Islander WHT – White OTH – Other or Multiracial

Clinic/Office Site Where Vaccine is Administered	Primary Care Physician Address/Phone Number

Insurance	**Insurance Key:** Commercial Medicare Medicaid	Insurance Type	**Insurance Type Key:** Horizon Aetna United Other:_________

Have you participated in a vaccine trial? Y/N

COVID-19 Immunization Screening and Consent Form*

Screening Questionnaire	Yes	No	Unknown
Are you feeling sick today?			
In the last 10 days, have you had a COVID-19 test or beentold by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?			
Have you been treatedwith antibodytherapy for COVID-19 in the past 90 days (3 months)? *If yes, when did you receive the last dose?*			
Have you ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing, to any vaccine or shot?			
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?*			
Are you pregnant or considering becoming pregnant?			
Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?			
Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have youhad any radiation treatments?			

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when the FDA has determined that circumstances exist to justify the emergency use of a drug and/or biological product during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make this vaccine available under an EUA is based on the FDA's determination: (i) of a public health emergency, and (ii) that the totality of scientific evidence available to the FDA shows that the vaccine may be effective in preventing COVID-19 and that the known and potential benefits of the vaccine outweigh its 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 and acknowledge that this vaccine is being made available under an EUA. I understand that if this vaccine requires two doses, 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 significant known and potential benefits and risks of the vaccination. as described, and the extent to which such benefits and risks are unknown.

I understand that I have the option to accept or refuse administration of the vaccine, of the consequences of refusing administration of the vaccine, and of the alternatives to the vaccine that are available and of the risks and benefits of those alternatives, if any.

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. In consideration of the foregoing, I hereby irrevocably assign and transfer to the vaccinating provider and/or its assignee all monies and benefits that may be available from my health insurance plan, Medicare, Medicaid or any third party who may be financially responsible for my medical care, for administering the vaccine I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify the provision of service or to secure payment. I also authorize the release of all information needed for 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 Thigh □ Right Thigh □ Nasal

Dosage □ 0.5 ml □ 0.25ml

□ 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 correctly and to the best of my ability.

Vaccinator Signature: ____________________

*** Use of this form is optional.**