Vaccine Screening and Consent Form

Patient Information

Last Name: _____ First Name: _____ Birth date: ___/___/_____ Age: ____ Sex: ☐ M ☐ F

Race: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Vaccine Requested: ☐ COVID-19 ☐ Flu

Do you have insurance? ☐Yes ☐No **Insurance Company: _____ RX BIN: _____ RX PCN: _____**

RX Group: _____ RX ID: _____ Relation to Subscriber: _____ Person Code: _____

Screening Questions	Yes	No
Are you sick today?		
Do you have a serious allergy to any medication, food, pet, environmental allergens, oral medications, or latex? If yes please list:		
Have you ever had a serious reaction or fainted after receiving a vaccine?		
Have you received a dose of COVID-19 vaccine? If Yes which product ☐ Pfizer ☐ Moderna ☐ J&J ☐ Other Date:_____		
Have you received passive antibody therapy as treatment for COVID-19 in the past 90 days?		
Do you have a seizure or brain disorder?		
Do you have a medical condition or take any medications that may weaken your immune system? If yes please list:		
Are you of 65 years of age or older?		
Are you between the ages of 18 and 64 and at risk of severe COVID-19?		
Are you between the ages of 18 and 64 and have frequent institutional or occupational exposure to SARS-CoV-2 that puts you at high risk of serious complication of COVID-19 including COVID-19?		
For women: Are you pregnant or breastfeeding?		

- If I have health insurance that covers myself or the child named above, I give permission for my insurance company to be billed for the costs of administering the vaccine being administered. The government is paying for the COVID-19 Vaccine itself, and I will not be billed for that portion of the cost of my immunization. If I am receiving a vaccine other than a COVID-19 vaccine I may be billed for the amount not covered by insurance
- I have received the Patient Privacy Notices regarding the use of my information for treatment, payment, or healthcare operations
- I understand that as required by state law, all immunizations will be reported to the Department of Public Health Massachusetts Immunization Information System (MIIS). I can access the MIIS Fact Sheet for Parents and Patients, at www.mass.gov/dph/miis, for information on the MIIS and what to do if I object to my or my family's data being shared with other providers in the MIIS.
- I have read, or have had explained to me, the Emergency Use Authorization (EUA) for COVID-19 vaccine or Vaccine Information Statement (VIS) for other vaccines that I will be receiving and had had an opportunity to ask any questions about the vaccines
- I have been advised to wait 15-30 minutes for observation after the administration of the vaccine

Please print name of signature if different from person receiving vaccine

_____

Patient or Parent/Guardian Signature_____Date_____

For Pharmacy Use Only Below

Date Given/EUA Date		
Vaccine, Lot#, Dose		
Clinic location		

Admin Site (circle one)	**Left Deltoid or Right Deltoid**	**Left Deltoid or Right Deltoid**

Signature of Vaccine Provider:

_____Date_____