Registration and Informed Consent for COVID-19 Immunization

Privacy Practice Notification Received? ☐ Yes ☐ No

Date: _____ Emergency Use Authorization Fact Sheet received? ☐ Yes ☐ No

PARTICIPANT'S INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Gender ☐ Male ☐ Female ☐ Other

Date of Birth _____ Age _____

Mailing Address: Street, City, State, Zip _____

Cell Phone _____ Home Phone _____

Race ☐ American Indian/Alaska Native ☐ Asian ☐ White ☐ Other

Check all that apply ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Decline

Hispanic? ☐ Yes ☐ No ☐ Decline

Insurance Type ☐ Medicaid ☐ Medicare ☐ Tricare ☐ Other Private Insurance ☐ Uninsured

Do you have any of the following Health conditions?

Asthma - Serious Heart Condition - Liver Disease - Chronic Lung Disease Diabetes - Severe Obesity - Immunocompromised

☐ Yes ☐ No ☐ Unknown

Occupation

☐ Construction, Landscaping, Other trades
☐ First Responders-Fire, Police, EMT
☐ Healthcare-Direct Patient contact
☐ Healthcare-No direct Patient contact
☐ Office worker-manager, supervisor, employee, clerical
☐ Oil Industry
☐ Plant workers, Manufacturing, Machine Operators, and assemblers
☐ School employee or contractor
☐ Seafood Industry
☐ Service-Entertainment
☐ Service-Restaurants, Bars, Catering, Fast Food
☐ Service-Retail, cosmetology, massage, elective services
☐ Service-Transportation
☐ Service-Tourism
☐ Skilled Agriculture
☐ Other

PARENT/GUARDIAN OR AUTHORIZED PERSON INFORMATION

Parent/Guardian First and Last Name _____

Cell phone or home phone number _____

COVID-19 Vaccine Screening Questions		Yes	No	Don't Know
1.	Are you feeling sick today?	☐	☐	☐
2.	Have you ever received a dose of a COVID-19 vaccine? If Yes, which vaccine product? _____	☐	☐	☐
3.	Do you have any allergies, such as to medications, food, or vaccine components?	☐	☐	☐
4.	Have you ever had a serious reaction to a vaccine or any injectable?	☐	☐	☐
5.	Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
6.	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
7.	Do you have cancer, leukemia, HIV/AIDs, or other immune system problem?	☐	☐	☐
8.	Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
9.	Have you received any other vaccines in the past 14 days?	☐	☐	☐
10.	For women: Are you pregnant or could become pregnant in the next month or currently breastfeeding?	☐	☐	☐

Please read and sign if you agree on the following page.

Informed Consent: *Please read and sign.*

My signature below indicates that:

- I have voluntarily chosen to receive the vaccination and consent to the administration.
- I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient or am authorized to consent on behalf of the client.
- I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization ("EUA") provided for the vaccine(s) to be administered.
- I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.
- I understand the benefits and risks of the vaccine(s).
- I will immediately alert the provider of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine.
- I understand I should remain in the area for 15 minutes after the vaccination for observation or 30 minutes if I have any history of severe allergic reaction or anaphylaxis.

_____ _____

Participant/Guardian/Authorized Representative Signature Date

OFFICE USE ONLY

Vaccine	1st/2nd dose	VFC/AVAP	Admin Site	Lot #	Manufacturer	EUA Fact Sheet Date
☐ Pfizer-BioNTech COVID-19 vaccine 0.3 mL		V07			**PFR**	
☐ Moderna COVID-19 vaccine 0.5 mL		V07			**MOD**	

Provider name (print) _____

Provider name (signature) _____

☐ Refer to _____ for _____

☐ Adverse Event _____ ☐ VAERS Report completed_____

***Adverse Event Type ☐ Local ☐ Syncope ☐ Anaphylaxis**

***(If there was an adverse event, an event type must be selected.)**

Arrival Time _____

Exit Time _____

Administration Sites	
Left Deltoid IM	LDI
Right Deltoid IM	RDI

Name_____

Birth Date_____

Date_____