El Camino Health

2500 Grant Road, Mountain View, CA 94040-4378
815 Pollard Road, Los Gatos, CA 95032

EL CAMINO HOSPITAL

# COVID-19 Immunization Screening and Consent Form

## PATIENT INFORMATION *(Please print clearly)*

| Last Name: | First Name: | MI: | Social Security Number: | Date of Birth: | Gender: |
|---|---|---|---|---|---|
| | | | | | |

| Phone Number: | Written Language Preference: ☐ English ☐ Other: | Needs Interpreter: ☐ Yes ☐ No | Religious Preference: |
|---|---|---|---|
| | | | |

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

**Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino

| Home Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

| Emergency Contact Name: | Emergency Contact Relation: | Emergency Contact Phone Number: |
|---|---|---|
| | | |

| Marital Status: ☐ Divorced ☐ Life Partner ☐ Married ☐ Single ☐ Widowed | Primary Care Physician: | Physician Phone: |
|---|---|---|
| | | |

| Employer: | Health Insurance Name: | Health Insurance ID: | Health Insurance Group: |
|---|---|---|---|
| | | | |

| **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked.If a question is not clear, please ask your healthcare provider to explain it. | Yes | No | Don't Know |
|---|---|---|---|
| **1.** Are you feeling sick today? | | | |
| **2.** Have you ever received a dose of COVID-19 vaccine?<br>• If yes, which vaccine product did you receive?<br>☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product _____ | | | |
| **3.** Have you ever had an allergic reaction to:<br>(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) | | | |
| • A component of a COVID-19 vaccine including either of the following: | | | |
| ○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures | | | |
| ○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids. | | | |
| • A previous dose of COVID-19 vaccine. | | | |
| • A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction. | | | |
| **4.** Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine? This would include food, pet, venom, environmental, or oral medication allergies.<br>(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) | | | |
| **5.** Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? | | | |
| **6.** Are you pregnant or breastfeeding? | | | |
| **7.** Do you have a history of or a risk factor for a blood clotting disorder? | | | |

Vaccination screening reviewed by: _____ Date:_____
(Name of staff member)

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## CONSENT FOR VACCINE ADMINISTRATION:

I have been given access to the COVID-19 Vaccine EUA Fact Sheet and have had a chance to have my questions answered. Information about the available Vaccine EUA is available here:

Pfizer Vaccine Fact Sheet: https://www.fda.gov/media/144414/download
Moderna Vaccine Fact Sheet: https://www.fda.gov/media/144638/download
Janssen Vaccine Fact Sheet: https://www.fda.gov/media/146305/download

I appreciate that it is not possible to consider every possible complication to vaccination. I understand the benefits and risks of the COVID-19 vaccine and request the vaccine be given to me. I consent to the sharing of information about my vaccine administration with the County of Santa Clara, the State Immunization Registry, and other applicable regulatory agencies as required. I understand that my record will be part of El Camino Health's Health Information Exchange and that I have the right to opt out of this arrangement by contacting El Camino Health's HIM Department.

By providing a telephone number to El Camino Health, you consent to receive autodialed and prerecorded calls and text messages from El Camino Health, and its vendors, relating to your relationship with the hospital, such as for treatment, billing, and eligibility for government health care programs. You may opt out of automated calls at any time by email to: patient_accounts@elcaminohealth.org.

By signing, I agree to the El Camino Health Terms of Use and Privacy Policies. I also agree to receive emails from El Camino Health, and I understand that I may opt out of El Camino Health emails at any time. Terms of Use information can be found at: www.elcaminohealth.org/terms-use, and Privacy Policies are at: www.elcaminohealth.org/website-privacy-policies.

## INSURANCE INFORMATION:

El Camino Health will be billing and sharing information with your insurance provider as applicable for administration of the COVID-19 vaccine. By signing this form, you authorize direct payment to El Camino Health of any insurance benefit otherwise payable to the undersigned for vaccine and services rendered at a rate not to exceed El Camino Health's usual and customary charges. It is agreed that payment to El Camino Health, pursuant to authorization, by an insurance company/Health Care Service Plan shall discharge that insurance company/Health Care Service Plan of any and all obligations under a policy to the extent of such payment. I also designate El Camino Health as my duly authorized representative to act on my behalf to pursue any claims, penalties, administrative and / or legal remedies against any health plan or responsible payer for any and all benefits due me for the payment of charges associated with services, including in any appeal, review, or grievance process; in any request for verification of coverage or request for authorization of services; in any pre-service and post-service claim or appeal; and if necessary, in litigation.

_____ _____ _____
Patient / Legal Representative Signature Date Time

_____
Relationship to Patient

If this document was translated/interpreted:

_____ or _____ _____ _____ _____
Signature of Translator Language Line ID Date Time Language

## STAFF USE ONLY BELOW

**Vaccine Given:**

| Vaccine Manufacturer | Dose Type: 1st or 2nd | Lot # | Exp. Date | Site of Admin |
|---|---|---|---|---|
| ☐ **PFIZER** | | | | ☐LA ☐RA |
| ☐ **MODERNA** | | | | ☐LA ☐RA |
| ☐ **JANSSEN J&J** | | | | ☐LA ☐RA |

**First Dose Information if First Dose Was Received Outside of El Camino Health:**

| 1st Dose Vaccine Manufacturer | 1st Dose Vaccination Date | 1st Dose Lot # | Facility Where 1st Dose Was Given |
|---|---|---|---|
| ☐ **PFIZER** | | | |
| ☐ **MODERNA** | | | |