COVID-19 IMMUNIZATION SCREENING AND CONSENT FORM- PATIENT INFORMATION *(Please print clearly)*

Last Name:	**First Name:**	**MI:**	SSN (optional):
Date of Birth (mmddyyyy):	**Age:**	**Gender:**	**Need Interpreter:** □ Yes □ No
Race: □ **Asian** □ **Black/African American** □ **White** □ **Other** □ **Native Hawaiian/Other Pacific Islander** □ **American Indian/Alaska Native**		**Ethnicity:** □ **Hispanic/Latino** □ **Not Hispanic/Latino**	
Home Address:	**City:**	**State:**	**Zip:**
Cell Number:	**Email:**		
Emergency Contact Name:	Emergency Contact Relation:	Emergency Contact Phone Number:	
Insurance Name:	RX Insurance ID #:	RX Insurance Group #:	
RX BIN #:	RX PCN #:	Primary Care Physician Name:	Physician Phone Number:

For vaccine recipients: The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **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? If yes, which vaccine did you receive? **Circle: Pfizer Moderna Janssen (Johnson & Johnson) Another product _____** **1st Dose Date**:_____ **2nd Dose Date**:_____			
3. Have you ever had an allergic reaction to a component of a COVID-19 vaccine including either of the following: (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. Itwould also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
➢ 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.			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?			

5. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have history of myocarditis or pericarditis
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs/therapies
- ☐ History of Guillain-Barre Syndrome (GBS)
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies:_____ _____

ATTESTATION FOR BOOSTER DOSE AFTER INITIAL 2-DOSE COVID-19 PFIZER or MODERNA mRNA COVID-19 VACCINE.

To receive the additional **PFIZER or MODERNA Covid-19 vaccine booster dose** after **at least 6 months** of completing the primary series, you must be authorized to receive it under federal eligibility criteria. Check a box below that applies:

- ☐ You are 65 years and older
- ☐ You are 18 years and older who lives in long-term settings
- ☐ You are 18 years and older who has underlying medical conditions
- ☐ You are 18 years and older who work or live in high-risk settings

FOR IMMUNOCOMPROMISED PEOPLE ONLY - ATTESTATION FOR ADDITIONAL DOSE AFTER INITIAL 2-DOSE COVID-19 mRNA VACCINE SERIES (PFIZER OR MODERNA)

To receive the additional Covid-19 vaccine dose after **at least 28 days** of completing the primary series of mRNA vaccine, you must be authorized to receive it under federal eligibility criteria. Check a box below to confirm you have moderate to severe immune compromise due to a medical condition or receipt of immunosuppressive medication or treatment:

- ☐ Active treatment of cancer
- ☐ Recipient of solid-organ transplant and taking immunosuppressive therapy
- ☐ Recipient of bone marrow or stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy
- ☐ Moderate or severe primary or acquired immunodeficiency (eg. DiGeorge or Wiskott-Alrich syndrome)
- ☐ Active treatment with immune suppressing medications such as high-dose corticosteroids (ie. ≥20 mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, TNF blockers, and other biologic agents that are immunosuppressive or immunomodulatory
- ☐ Advanced or untreated HIV infection

I certify that I am: (a) the patient and at least 18 years of age or (b) the parent or legal guardian of the patient. Further, I hereby give my consent to the healthcare provider to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Emergency Use Authorization Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. I acknowledge that, depending upon my state's law, I may prevent the disclosure of my immunization information by the applicable Provider to the State Registry by using the opt-out form. The Provider will, if my state permits, provide me with an Opt-Out Form upon request. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the Provider reporting my immunization information to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information as required or permitted by law. I voluntarily authorize and direct my healthcare provider at El Camino Health / ECH Outpatient Pharmacy to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at El Camino Health / ECH Outpatient Pharmacy, my Primary Care Physician, my insurance and/or state or federal registries, where required, for the purpose of treatment, payment or other healthcare operations. I further agree to be fully financially responsible for any cost sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or once processed thru my insurance.

NAME:_____**SIGNATURE:** _____**Relationship:**_____ **DATE:** _____

(**Patient please sign form. If minor**- *Parent, guardian, or authorized representative please print your name and sign above.*)

*****BELOW FOR PHARMACY USE ONLY - VACCINE ADMINISTERED*****

COVID-19 Vaccine Manufacturer	NDC	Dose Type 1st, 2nd, 3rd or Booster	Dose (ml)	VIS or EUA Provided	Lot #	Exp.Date	Site of Admin DELTOID Muscle
							☐LA ☐RA

FORM REVIEWED & VACCINE ADMINISTERED BY:_____DATE:_____RPH:_____V102221