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 Phone #:	**Email:**		ECH EMPLOYEE #:
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. **Circle your response to each answer below.**

1. Are you feeling sick today?	YES	NO
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**:_____ **3rd Dose Date**:_____ **4th Dose Date:**_____	YES	NO
3. Are you here to receive a booster dose? If yes, do you self-attest that you currently meet the qualification as established by the CDC, and/or established by the State?	YES	NO
4. 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. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)		
a. A component of a COVID-19 vaccine	YES	NO
b. A previous dose of COVID-19 vaccine	YES	NO
5. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?	YES	NO
6. **Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised?** (This would include, but not limited to, treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency)	YES	NO
7. Have you received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T cell therapies?	YES	NO

8. Check all that apply to you:

- ☐ Have a history of COVID-19 disease within the past 3 months?
- ☐ Have history of myocarditis or pericarditis
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ History of Guillain-Barre Syndrome (GBS)
- ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
- ☐ Had a severe allergic reaction to any food or oral medication allergies:_____

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.

ALL VACCINE RECIPIENT MUST COMPLETE THIS SECTION.

Print Name:_____ **Signature:** _____

Relationship:_____ **Date:** _____

If vaccine recipient is a minor- the Parent, guardian, or authorized representative please print your name and sign above

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

*****AFFIX VACCINE LABEL AND PROCESSED LABEL BELOW OR COMPLETE SECTION MANUALLY*****

COVID-19 VACCINE MFC	NDC #	DOSE TYPE: 1ST/ 2ND/3RD/BOOSTER	DOSE (ML)	VIS OR EUA DATE	LOT #	EXP. DATE	SITE OF ADMIN
							LEFT ARM RIGHT ARM

FORM REVIEWD & VACCINE ADMINISTERED BY: _____DATE:_____RPH:_____V051622