COVID-19 VACCINE SCREENING AND CONSENT FORM

Administration Facility Name/Facility ID: _____

SECTION 1: INFORMATION ABOUT PATIENT (PLEASE PRINT)

Name: Last:	First:	Middle Initial:		
Date of Birth: Month Day Year	**Mobile Phone Number (Patient or Guardian): ( )**			
Address:	**Apt/Room #:**			
City:	**State:**	**Zip:**		
Name of Legal Guardian: Last:	First:	Middle Initial:		
Sex (Gender assigned at birth) ☐ Female ☐ Male	**Race** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American	☐ Native Hawaiian or other ☐ Pacific Islander ☐ White	☐ Other Asian ☐ Other Nonwhite ☐ Other Pacific Islander	☐ Unknown
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown				

Primary Insurance Carrier ID #:_____ Grp #: _____
Insurance Company :_____ Insurance Company Phone #_____
Insured's Name:_____ Relationship:_____ Insured's Date of Birth_____
Secondary Insurance Carrier ID #:_____ Grp #: _____
Insurance Company :_____ Insurance Company Phone #_____
Insured's Name:_____ Relationship:_____ Insured's Date of Birth_____

Designation of COVID-19 vaccination dose number? ☐ First Dose ☐ Second Dose ☐ Third Dose*

SECTION 2: COVID-19 SCREENING QUESTIONS

Please check YES or No for each question.	**Yes**	**No**
1. Do you have today or have you had at any time in the last 10 days a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?		
2. Have you tested positive for and/or been diagnosed with COVID-19 infection within the last 10 days?		
3. Have you had a severe allergic reaction (e.g. needed epinephrine or hospital care) to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
4. Have you had any COVID-19 Antibody therapy within the last 90 days (e.g. Regeneron, COVID Convalescent Plasma, etc.)		

SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE

Please check YES or No for each question.	**Yes**	**No**
5. Do you carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, foods, vaccines or latex?		
6. For women, are you pregnant or is there a chance you could become pregnant?		
7. For women, are you currently breastfeeding?		
8. Are you immunocompromised or on a medication that affects your immune system?		
9. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
10. Are you a female age 18 to 49 years old receiving the Janssen (Johnson and Johnson) COVID-19 vaccine?		
11. If you are under the age of 18 are you and/or your guardian aware that you are only eligible to receive the Pfizer vaccine?		
12. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive:		
*13. If this is your third dose, are you moderately to severely immunocompromised (e.g. solid organ transplant recipient, immunosuppressant medications, active treatment for cancer, etc.) Note that a third dose of mRNA vaccine is only recommended at this time for those who are moderately to severely immunocompromised and must occur at least 28 days after the previous mRNA vaccine dose.		

- I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 12 years of age (for Pfizer vaccine consent only); or (c) legally authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Florida Department of Health (DOH) or its agents to administer the COVID-19 vaccine.
- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals either 12 years of age or older (Pfizer only) or 18 years of age and older (Pfizer, Moderna and Johnson and Johnson) ; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine 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.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the State of Florida, the Florida Department of Health (DOH), the Florida Division of Emergency Management (FDEM) and their 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 listed above.
- I acknowledge that: (a) I understand the purposes/benefits of Florida SHOTS, Florida's immunization registry and (b) DOH will include my personal immunization information in Florida SHOTS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize DOH, FDEM, or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to DOH, FDEM, or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if DOH invoices me after the time of service, upon receipt of such invoice.
- I acknowledge receipt of the DOH Notice of Privacy Practices.

Signature of Patient or Authorized Representative_____ **Date:** _____

Print Name of Representative and Relationship to Person Receiving Vaccine: _____

Site (LD/RD)	Route	Manufacturer (MVX)	Lot # Unit of Use/ Unit of Sale	Expiration Date	Date of EUA Fact Sheet
	IM				

Administered at location: facility name/ID	
Administered at location: Type	
Administration Address:	
CVX (product)	
Sending organization:	

Vaccinator Print Name:_____ **Signature:**_____ **Date:** _____

Vaccine administering provider suffix: _____