COVID-19 Vaccine Informed Consent

PATIENT INFORMATION

Last Name: _____ **First Name**: _____ **Middle Name**: _____

Email Address: _____ **Birth Date**: _____ **Age:** _____
Month / Day / Year *Must be 16 or Older*

Street Address: _____ **City:** _____ **State**: VA **Zip**:_____

County/Locality of Residence: _____ **Daytime Phone**: _____

Patient's Legal Representative: _____ **Relationship**: _____

Gender:	Male Female	**Race**:	☐American Indian/Alaska Native ☐Hawaiian Native or Other Pacific Islander	☐ Asian ☐ Black/African American	☐ White ☐ Not Stated	**Ethnicity**:	☐ Hispanic or Latino ☐ Non-Hispanic ☐ Unknown

INSURANCE INFORMATION

☐ **Medicaid/Medallion/CCC+:**_____ ☐ **Private Insurance:**_____
Plan Name *Plan Name*

Member ID #_____ Policy/Member ID # _____

☐ **Medicare Part B:**_____ Group # _____
Plan Name

Beneficiary ID #_____ Policy Holder's Name: _____

COVID-19 SCREENING QUESTIONS

	No	Yes	Don't Know
Have you had a severe allergic reaction to this vaccine?			
Do you have a known history of a severe allergic reaction to any components of this vaccine such as lipids, potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, or sucrose? (Full list of ingredients is available in the Fact Sheet for Vaccine Recipients and Caregivers or from your health care provider.)			
Are you under the age of 12 years?			
In the past two weeks (14 days) have you tested positive for COVID-19 or are you currently being monitored for COVID-19?			
In the past two weeks (14 days) have you had exposure to a person who tested positive for COVID-19?			
Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?			

MEDICAL SCREENING QUESTIONS

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "**yes**" to any question, it does not necessarily mean you should not be vaccinated. It just means that additional questions must be asked. If a question is not clear, please ask your health care provider to explain it.	No	Yes	Don't Know
Do you have a history of severe allergic reaction (e.g., anaphylaxis) to another vaccine or injectable medication? If yes, what vaccine or injectable medication:_____			
Do you have a bleeding disorder or are you on a blood thinner?			
Are immunocompromised or are on a medicine that affects your immune system (such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; or have you had radiation treatments)?			
Do you have any allergies (reactions to any vaccines or medications such as neomycin, polymyxin, thimerosal; foods such as eggs, gelatin, MSG; or latex)?			
Have you experienced anaphylaxis or an allergic reaction requiring emergent care in the past?			
In the past 2 weeks have you received any vaccinations such as MMR, Shingrix or Varicella, or received a TB skin test?			
Do you have any long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (ex: diabetes)?			
Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Chron's disease, or any other immune system problem?			

MEDICAL SCREENING QUESTIONS CONTINUED			
	No	Yes	Don't Know
Have you had a seizure, brain, or other nervous system problem, such as Guillain-Barre Syndrome or other nervous system problems?			
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin, or an antiviral drug?			
Are you pregnant or do you plan to become pregnant? If yes, please see important information below in section "About The Vaccine."			
Are you breastfeeding? If yes, please see important information below in section "About The Vaccine."			

ABOUT THE VACCINE

For complete information about the vaccine This Fact Sheet may have been updated. For the most recent Fact Sheet for Recipients and Caregivers, a copy of which is being provided to you with this informed consent. Current copies of the Fact Sheet are available online at www.cvdvaccine.com and you should look here for updates.

The vaccine may prevent you from getting COVID-19. There is no U.S. Food and Drug Administration (FDA) approved vaccine to prevent COVID-19. The FDA has authorized the emergency use of this vaccine to prevent COVID-19 in individuals 16 years of age and older under an Emergency Use Authorization (EUA). Note that pregnant and breastfeeding women have not been included in clinical trials for the COVID-19 vaccine, and the CDC Fact Sheet does not discuss any specific risks to these patients. Although the FDA offers use of the vaccine for pregnant and breastfeeding women, the potential side effects are unknown at this time. Potential side effects to the mother, neonate or infant may include: miscarriage; birth defects; and serious injury or death to breastfeeding infants.

The vaccine will be given to you as an injection into the muscle. The vaccine is given in a series of 2 doses given 3 weeks apart. If you receive one dose of the vaccine, you should receive a second dose of this same vaccine 3 weeks later to complete the vaccination series.

Risks of the vaccine include side effects and there is a chance that the vaccine could cause a severe allergic reaction. If you experience a severe allergic reaction, call 9-1-1, or go to the nearest hospital. Call the vaccination provider or your healthcare provider if you have any side effects that bother you or do not go away.

CONSENT FOR VACCINATION

☐ I hereby authorize the administration of the COVID-19 vaccine to myself or to the person named below for whom I am the legal representative.

☐ I have read or have had explained to me the information contained in the Fact Sheet for Recipients and Caregivers: Emergency Use Authorization (EUA) of COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19) and understand the risks and benefits of the vaccine and alternatives to the vaccine (that is, not receiving the vaccine or waiting for other versions of the vaccine). If I am pregnant or breastfeeding, I understand that the specific risks of the Covid vaccine to pregnant and breastfeeding women are unknown at this time.

☐ I have had the opportunity to ask questions about this immunization [and any questions I had about the COVID-19 vaccine have been answered to my satisfaction.

☐ I believe the benefits outweigh the risks, and I accept full responsibility for any reactions that may result from my receipt of the immunization or the receipt of the immunization by the person named below for whom I am the legal representative.

☐ I agree that my vaccine-related health information may be required to be or may voluntarily be disclosed to my health care provider, my insurance plan, and state or federal registries or other public health authorities, for purposes of treatment, payment or health care operations. I also agree that the organization providing my vaccine may use and disclose my health information as described in its Notice of Privacy Practices.

☐ CHECK THIS BOX ONLY IF YOU ARE PREGNANT OR BREASTFEEDING: I understand that pregnant and breastfeeding women have not been included in clinical trials for the COVID-19 vaccine. I understand that the specific risks of the Covid vaccine to pregnant and breastfeeding women are unknown at this time and could include miscarriage, developmental damage, and/or death to breastfeeding children. Understanding this, I want to proceed with administration of the COViD-19 vaccine.

X_____ _____

Signature of patient to receive vaccine (or parent, guardian, or authorized representative) Date

_____

Printed name

_____

Relationship to patient receiving vaccine (if not self)

If signing on behalf of the patient, you are stating that you are authorized to provide the required consent on behalf of the patient.

VACCINE ADMINISTRATION INFORMATION / FOR IMMUNIZER USE ONLY

Administration Date	Vaccine	VIS Date		Manufacturer	
Lot #	Exp. Date	IM Route	Series	L R Site	Volume (mL)
Vaccinator Signature			Date		