COVID-19 VACCINE SCREENING AND CONSENT FORM

SECTION 1: INFORMATION ABOUT YOU (PLEASE PRINT)

Name:	**Age:**	**Social Security #:**
Date of Birth:	**Mobile Phone Number:**	
Address:	Driver's License/Photo ID Number:	
City, State, Zip:	Preferred Language:	
If Minor, Name of Legal Guardian: Last:	First:	Middle Initial:
Sex (Gender assigned at birth)	**Race:**	Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Primary Insurance Member ID #: _____ Grp #:_____

Insurance Company :_____

Insured's Name: _____ Insured's Date of Birth_____

For statistical reporting only:

* Check your living arrangements: □ Own/Rent □ Shelter □ Homeless □ Public Shelter □Living with friend/doubling up
□Street/Car □Transitional □Other _____ □Public Housing
* In the past two years, or prior to retirement or disability:
Have you or the head of your household worked in agriculture? □Yes □No
Did you or the head of your household move from this area to another County or State in search of agricultural work? □Yes □No
Has your family lived in this area and earned more than half their income from seasonal agriculture? □Yes □No

Have you received any doses of the COVID-19 vaccination? ☐ First Dose ☐ Second Dose ☐Third Dose ☐Booster

What vaccine have you previously received? ☐ Moderna ☐ Pfizer ☐ Janssen(Johnson & Johnson)

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, Bamlanivimab, 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. If this is your third dose or booster dose of an mRNA (Pfizer-BioNTech or Moderna) COVID-19 vaccine or your second dose (booster) of Janssen (Johnson and Johnson) COVID-19 vaccine and you meet one or more of the following: 1) Moderately to severely immunocompromised (e.g. solid organ transplant recipient, immunosuppressant medications, active treatment for cancer, etc.) and at least 28 days have passed from the completion of your mRNA COVID-19 primary series. 2) At least 6 months have passed since the completion of an mRNA COVID-19 vaccine primary series 3) At least 2 months have passed since the initial dose of your Janssen (Johnson and Johnson) COVID-19 vaccination and you are 18 years of age or older.		

* 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 5 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 Premier Community HealthCare Group, Inc. (PCHG) or its agents to administer the COVID-19 vaccine.
*Currently, Pfizer is the only COVID-19 vaccine product that has been fully approved and licensed by FDA. This FDA approval and license is for use in individuals 16 years of age and older only.
* I understand that this product (other than Pfizer for usage in ages mentioned above only) 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 5-15 years of age (Pfizer only) or 18 years of age and older (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 Premier Community HealthCare Group, Inc. (PCHG) 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) PCHG 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 PCHG 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 PCHG 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 PCHG invoices me after the time of service, upon receipt of such invoice.

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				

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

Office Use:

Registered & Insurance Verification: _____ Administered Vaccine: _____

EHR Documentation: Immunization Module _____ POMIS: Demographics Updated _____

Encounter Note _____ Charges Posted _____

Charges Dropped _____ Consent Scanned _____