COVID-19 Screening & Consent Form

First Name:_____ **Last Name**:_____ **MI**:_____

DOB:_____ **AGE**:_____ **GENDER**:_____ **Phone**: (___)_____
MM/DD/YYYY

Address:_____ **City**:_____ **St**:_____ **ZIP**:_____

Race: o White o Black o Asian o Pacific Islander o Native American o Other **Ethnicity:** o Hispanic/Latino o Not Hispanic/Latino

Mother's Maiden Name (Required for Immunization Record):_____

Please circle **YES** or **NO** for the following questions **and** answer **ALL** questions:

Are you feeling sick today?	**Yes**	**No**
Have you received a dose of COVID-19 vaccine? If yes, which product did you received? O Pfizer Last date of administration: _____ O Janssen (J&J) Last date of administration:_____ O Moderna Last date of administration: _____	**Yes**	**No**
Are you allergic to polyethylene glycol (found in laxatives, bowel preps, cough meds, or some cosmetics)	**Yes**	**No**
Have you every had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or had to go to the hospital? If yes, please explain:	**Yes**	**No**
Have you ever felt faint or fainted after receiving a vaccine or medical procedure?	**Yes**	**No**
Are you female between 18 and 49 years of age?	**Yes**	**No**
Are you male between 12 and 29 years of age?	**Yes**	**No**
Have you tested positive for COVID-19? **If yes, date of positive lab results:**	**Yes**	**No**
Have you received antibody therapy as a treatment for COVID-19? **If yes, when:**	**Yes**	**No**
Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?	**Yes**	**No**
Are you immune compromised?	**Yes**	**No**
Do you have a history of myocarditis or pericarditis?	**Yes**	**No**
Do you have a bleeding disorder OR are you on a blood thinner? **If yes, which one?**	**Yes**	**No**
Have you received hematopoietic cell transplant or CAR-T-cell therapies since last vaccine?	**Yes**	**No**
Do you have a history of heparin-induced thrombocytopenia (HIT)?	**Yes**	**No**
Do you have a history of Guillian-Barre Syndrome (GBS)?	**Yes**	**No**
Have you received dermal fillers?	**Yes**	**No**
Are you pregnant or breastfeeding? **If yes, circle which one?**	**Yes**	**No**

I have received, read, and understand the "Fact Sheet for Recipients and Caregivers" about the "Emergency Use Authorization (EUA) for the COVID-19 vaccine. I understand the benefits and risks of receiving this COVID-19 vaccine. I have had an opportunity to ask questions which were answered to my satisfaction. I hereby provide informed consent that the vaccine indicated below be given to me or to the person named above for whom I am authorized to make this request. Immunization given today will be entered into CAIR.

Patient/Guardian's Signature: _____ _____ Date:_____
Relationship to person above

- Pharmacy Use Only -

Date	Vaccine Mfg	Lot/Expiration	Admin by/Title	License #	Route IM
	O Moderna O J&J O Pfizer				Left Right
CAIR ID# DE-012245 **VIS**		**Admin Time:**		**Release Time:**	