COVID-19 Vaccination Consent under Emergency Use Authorization

PATIENT DEMOGRAPHIC INFORMATION

Last Name: ___________________________ First Name: ____________________ Middle Initial: ____

Date of Birth: _____________ Age: ___ Sex: Male □ Female □ Transgendered □ Other □ __________

Race: White □ Black □ Asian □ Pacific Islander □
American Indian/Alaskan Native □ None Specified □ Refuse □

Hispanic Ethnicity: Yes □ No □
Unknown □ Refused □

Address:

City:

State:

Zip Code:

Cell Phone:

Email:

Private or employer insurance □ Underinsured □ Uninsured □ Medicaid □

HEALTH HISTORY

	If YES to Q1-Q5 please comment and ensure a clinician approves the COVID vaccine order and administration. A nurse may review this consent and order/administer the COVID-19 vaccine with the Standing Order as long as no contraindications are identified.	**YES**	**NO**	**UNKNOWN**
1.	Are you feeling sick today? (Do NOT give vaccine if moderate or severe illness)	☐	☐	☐
2.	Have you ever had a serious reaction after any vaccination or injectable medication including a previous dose of the COVID-19 vaccine? (If severe then do NOT give the vaccine)	☐	☐	☐
3.	Have you ever had a severe allergic reaction (eg anaphylaxis) to something? For example, a reaction (unable to breathe/throat swelling) for which you were treated with epinephrine or Epi Pen or for which you had to go to the hospital? (If yes and severe, then a 30 minute monitoring time is recommended) Comments:	☐	☐	☐
4.	In the past 14 days have you had contact with a confirmed COVID-19 person?	☐	☐	☐
5.	In the last 90 days have you had IV antibody treatment for COVID or MIS-C/A? (Vaccine may need to be postponed during quarantine or for 90 days) Comments: ________________________	☐	☐	☐

Clinician Signature if Verified Yes Answer in Q1-Q5: _______________________________

6.	In the past 90 days have you tested positive for COVID? (Quarantine should be completed)	☐	☐	☐
7.	Have you had any vaccines in the last 14 days? (OK to give vaccine)	☐	☐	☐
8.	Have you ever received a dose of COVID-19 vaccine? Type: _____________ Date of Dose 1: ___________ Date of Dose 2: ___________	☐	☐	☐

9. Check all that apply to you: these answers help us to direct counseling to support your healthcare; they are not contraindications.

- □ Am a female between ages 18 and 49 years old
- □ Am a male between ages 12 and 29 years old
- □ Have a history of myocarditis or pericarditis
- □ Have a history of heparin-induced thrombocytopenia (HIT)
- □ Have a history of fainting with vaccinations or blood draws
- □ History of Guillain-Barré Syndrome (GBS)
- □ Have received dermal fillers
- □ Am currently pregnant or breastfeeding
- □ Taking a blood thinner
- □ Have a bleeding disorder

BOOSTER DOSE ELIGIBILITY (Must be 18 or older; 12 or older for Pfizer booster - if primary series was Pfizer)

10. I desire a booster shot with the following vaccine type:

- □ Pfizer BioNTech (Comirnaty®)
- □ Moderna (SpikeVax®)
- □ Johnson & Johnson/Janssen
- □ Unsure

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3RD DOSE ELIGIBILITY (Pediatric Pfizer ages 5-11 and Moderna ages 18 and older)

□ I have a weakened immune system (i.e. HIV infection, cancer) or take immunosuppresive drugs or therapies for one of the following conditions:

□ Active treatment for solid tumor and hematologic malignancies

□ Receipt of solid-organ transplant and taking immunosuppressive therapy

□ Receipt of CAR-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppresion therapy

□ Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)

□ Advanced or untreated HIV infection

□ Active treatment with high-dose corticosteroids (i.e., ≥20mg prenisone or equivalent per day). Alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory

_______ By initialing here, I confirm that I have one of the conditions or risks above and I desire a booster vaccine. Affinia Healthcare recommends that patients consider their individual risks and benefits of vaccination and consult with their healthcare provider if support is needed before vaccination.

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICP to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The CICP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use of covered countermeasures identified in a PREP Act declaration. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV–2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any such product. Information about the CICP and filing a claim is available by calling 1-855-266-2427 or visiting https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine

Print Name:	**Today's Date:**
Signature of Patient	**Relationship to Client**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print name) ________________________, acknowlege and agree that I have received or have been advised of the Affinia Healthcare's Notice of Privacy Practices and where I can obtain any revisions made to this Notice.

Client Signature/Legal Representative	**Relationship to Client**	**Today's Date**

For Clinic Use Only

Manufacturer:	**Brand**	**Lot Number**
Dose Number: □ 1 □ 2 □ Booster	**Expiration Date** ____/___/_______	**Date Administered** ____/___/_______
EUA Fact Sheet Date: ____/___/_______	**EUA Fact Sheet Given Date:** ____/___/_______	**Injection Site (Deltoid):** L □ R □ **Vaccine Dose:** _________________

DOCUMENTATION REQUIRED FOR MINOR: □Yes □No

- □ A minor under the care of a parent/guardian that physically appears and signs the requisite paperwork for the minor to receive the vaccination.
- □ Notarized written consent in cases where the parent/guardian is not present at the vaccination.
- □ Un-notarized written consent, if verbal confirmation can be obtained by telephone, in cases where the parent/guardian are not present at the vaccination
- □ A minor under the care of a relative caregiver. The affidavit as explained in §431.058, RSMo, must be provided for the minor to receive the vaccination.
- □ A minor under the care of the Department of Social Services, written consent from Children's Division (or designee) or Division of Youth Services must be provided for the minor to receive the vaccination.
- □ A minor married, pregnant, or minor parent, under §431.061, RSMo (minor parent, married minor, etc.). Documentation shown at time of vaccine: ____
- □ "Homeless youth" (qualified youth) as provided in §431.056, RSMo, such documentation may be letters from persons/entities such as (but not limited to): a director or designee fo a governmental or nonprofit agency that receives public or private funding to provide services to homeless persons; a location education agency liaison for homeless children and youth designated under 42 U.S.C. Section 11432(g)(1)(J)(ii); a school social worker/counselor; or a licensed attorney representing the minor in any legal matter.

Administered by Name and Title:
Agency:
Agency Address:
Clinic Administration Address: (Revised 1.6.22)