Hancock Public Health

COVID-19 VACCINE INFORMATION AND CONSENT FORM

Section 1: Patient Information

FIRST NAME: ______________________________ MIDDLE INITIAL ______ LAST NAME: ___________________________

DATE OF BIRTH: ______________ AGE: ______ PHONE NUMBER: ____

STREET ADDRESS: ____ CITY: __________________________________

STATE: __________________________ ZIP CODE: ____________________ COUNTY OF RESIDENCE: _________________

Section 2: Patient Insurance Information

PRIMARY INSURANCE	SECONDARY INSURANCE
Policyholder______________________________	Policyholder____________________________
Policyholder date of birth_________________	Policyholder date of birth______________
Social Security #__________________________	Social Security #_______________________
Relationship to patient____________________	Relationship to patient_________________

Is this your ☐ **FIRST**, ☐ **SECOND**, ☐ **THIRD** (immunocompromised-28 days after 2nd dose)

OR BOOSTER ☐ (at least 2 months after J&J/Janssen vaccine or 6 months after 2nd dose of Moderna or Pfizer CoVID-19 vaccine) **dose of the COVID-19 Vaccine?**

- If this is your 2nd or 3rd dose, what were the dates of your previous doses? 1st _______ 2nd ________

Section 3: Screening Questions

Please answer the health questions below:	Yes	No	Not Sure
1. Have you ever had a severe allergic reaction to a vaccine or any injection in the past?			
2. Have you ever tested positive for COVID-19 or had a doctor tell you that you had COVID-19?			
3. Have you been identified as either a probable or confirmed case of COVID-19 in the last 2 weeks?			
4. Have you received antibody therapy (monoclonal or convalescent plasma) for COVID-19 in the last 3 months?			
5. Do you have any serious health conditions?			
6. Do you have a weakened immune system (i.e. from HIV or cancer) or are you on immunosuppressive drugs?			
7. Do you have a bleeding disorder or are you taking a blood thinner?			
8. Are you pregnant or breastfeeding?			
9. Do you feel sick today?			

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Section 4: Eligibility and Consent

Please visit the CDC website cdc.gov/coronavirus/2019-ncov/vaccines/index.html to learn about the benefits and risks (VIS) of the COVID-19 vaccine. Please visit our website (posted at the clinic) to read our Privacy Policy.

Please initial below

☐ I have been given a copy and have read, or have had explained to me, the information in the FACT SHEET for the COVID-19 vaccine. I have had the chance to ask questions that were answered to my satisfaction.

☐ By signing below, you agree that 1) you reviewed both the VIS and Privacy Policy, 2) you understand the benefits and risks of the vaccine and you are asking that the vaccine be given to you or the person named on this form for whom you are authorized to make this request, 3) you hereby consent that we can bill your insurance, if applicable, 4) you authorize the release of this vaccination record and all information on this form to your state's Immunization Program and the CDC, and 5) we can release this record to your doctor, school, or employer if requested. If the person who is being vaccinated is age 17 or under, by signing below you agree that you are authorized to consent to the vaccination of the patient and the patient on this form may receive vaccine with or without you, as the parent or guardian, present at the time of vaccination. After receiving your vaccine, we recommend you wait at least 15 minutes. If you leave the vaccination site before 15 minutes has passed after your vaccination you assume any risks associated with not waiting the recommended amount of time. Please be aware that staff may be taking pictures for social media and clinic improvement purposes. If you do not want your picture to be taken, please let us know at the clinic.

Additional Consent for the 3rd dose- immunocompromised (28 days after 2nd dose)

☐ I understand a third dose of the COVID-19 vaccine is authorized and recommended for moderately to severely immunocompromised individuals who initially received the Pfizer or Moderna COVID-19 vaccine. I am eligible to receive a third dose of the COVID-19 vaccine because I have:

- Been receiving active cancer treatment for tumors or cancers of the blood.
- Received an organ transplant and am taking medicine to suppress my immune system.
- Received a stem cell transplant within the last 2 years or am taking medicine to suppress my immune system.
- Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome).
- Advanced or untreated HIV infection.
- Active treatment with high-dose corticosteroids or other drugs that may suppress my immune response.
- Another medical condition that causes my immune system to be moderately to severely compromised and for which my treating physician recommends I receive a third dose of the COVID-19 vaccine.

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Additional Consent for 3rd dose- Booster (6 months after 2nd dose)

☐ I understand that the U.S. Food and Drug Administration (FDA) and Centers for Disease Control and Prevention (CDC) have authorized a booster dose of the Pfizer-BioNTech/Comirnaty, Johnson and Johnson, and Moderna COVID-19 vaccine for fully vaccinated people to maximize ongoing protection against COVID-19. People ages 18 years and older who received a J&J/Janssen COVID-19 vaccine at least 2 months ago should get a booster shot. People ages 18 years and older who received the Moderna, or Pfizer COVID-19 vaccine should get a booster dose at least 6 months after their 2nd dose. I am eligible because I:

- am 65 years of age or older
- am a resident of a long-term care setting
- am 50-65 years old with certain underlying medical conditions (i.e. cancer, chronic kidney disease, chronic lung diseases, neurological conditions, diabetes, heart conditions, liver diseases, weakened immune system, obesity etc.)
- am 18 to 49 years old with certain underlying medical conditions (i.e. cancer, chronic kidney disease, chronic lung diseases, neurological conditions, diabetes, heart conditions, liver diseases, weakened immune system, obesity, pregnancy, substance use disorder etc.)
- am 18 years old or older and am at increased risk for COVID-19 exposure and transmission because of my job or living in an institutional setting.

- *A booster shot is based on their individual benefits and risks. The CDC has indicated that this is a determination made by the vaccine recipient.*

Section 4: Signature

Name of patient or guardian (print): ____

Signature of Patient of guardian: ____

Relationship to Patient: ____ Date: __________

Section 5: Vaccination Record

FOR OFFICE USE ONLY

Date	Manf.	Lot #	Exp.	Dose	Route	Site	VIS/fact sheet given	Nurse Signature