Griffith & Feil DrugCOVID-19 VaccinationConsent and Screening Form

INDIVIDUAL INFORMATION			
Last Name:	First Name:	M.I.	Date of Birth / /

Contact Info			
Address:	Gender:	Race/Ethnicity:	Phone

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. I hereby give my consent to the healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine. I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Vaccine Information Statements or Fact Sheet on the 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. Further, I acknowledge that I have been advised to remain near the vaccination location for observation after administration.

_______I certify that I have received and reviewed the attached COVID-19 vaccine fact sheet.
(Initial)

______ I understand and have been advised that this vaccine is a 2-dose vaccine, and that a second (Initial) clinic will be offered at the same location and within the appropriate time frame, to administer the 2nd dose. However, I acknowledge and agree that it is my responsibility to ensure that I timely obtain the 2nd dose should I change employment, leave the facility, or otherwise not participate in the 2nd clinic.

***In signing below, I hereby consent for COVID-19 vaccination.

____
PLEASE PRINT PATIENT OR PARENT/GUARDIAN'S NAME

____
SIGNATURE PATIENT OR PARENT/ GUARDIAN'S (if less than 18)
(If signing on behalf of the patient, you are stating that you are authorized to provide the required consent on behalf of the patient.)

____
DATE

Prescription Insurance Information

Please present card at time of vaccination

BIN # (6 digits)____________________________

PCN______________________________________

Rx insurance ID#___________________________

Rx insurance Group #______________________

Name & location of current pharmacy that we may contact if we have billing issues

____

If no insurance please list Driver's License Number or SSN

____

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Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Name ______________________

Age __________

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	**No**	**Don't know**
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product ______			
• Have you received a complete COVID-19 vaccine series *(i.e., 1 dose Janssen or 2 doses of an mRNA vaccine [Pfizer-BioNTech, Moderna])*?	☐	☐	
• Did you bring your vaccination record card or other documentation?	☐	☐	
3. Have you ever had an allergic reaction to: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including either of the following: ○ Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
4. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

5. Check all that apply to you:

☐ 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

☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies

☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum

☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection

☐ Have a bleeding disorder

☐ Take a blood thinner

☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies

☐ Have a history of heparin-induced thrombocytopenia (HIT)

☐ Am currently pregnant or breastfeeding

☐ Have received dermal fillers

☐ History of Guillain-Barré Syndrome (GBS)

Form reviewed by ______________________ **Date** ______________