Registration and Informed Consent for Immunization

Privacy Practice Notification Received? ☐ Yes ☐ No

Date: _____ Emergency Use Authorization or VIS Fact Sheet received? ☐ Yes ☐ No

PARTICIPANT'S INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Gender ☐ Male ☐ Female ☐ Other

Date of Birth _____ Age _____

Mailing Address: Street, City, State, Zip _____

What City/Village do you currently live in? _____

Cell Phone _____ Home Phone _____

Race ☐ American Indian/Alaska Native ☐ Asian ☐ White ☐ Other

Check all that apply ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Decline

Hispanic? ☐ Yes ☐ No ☐ Decline

Insurance Type ☐ Medicaid ☐ Medicare ☐ Tricare/VA ☐ Other **P**rivate Insurance ☐ Uninsured

GUARDIAN OR AUTHORIZED PERSON INFORMATION

Guardian First and Last Name _____

Cell phone or home phone number _____

Vaccine Screening Questions	Yes	No	Don't Know
1. **Are you feeling sick today?**	☐	☐	☐
2. **Do you have a History of Guillain-Barré Syndrome (GBS)?**	☐	☐	☐
3. **Do you have any allergies, such as to medications, food, or vaccine components?** (If yes please tell your vaccinator so they can ask you some additional questions)	☐	☐	☐
4. **Have you ever had a serious reaction to a vaccine or any injectable?**	☐	☐	☐
COVID Vaccine Only:			
5. **Have you ever received a dose of a COVID-19 vaccine? If Yes, which vaccine product? _____**	☐	☐	☐

6. **Check all that apply to you:**

☐ Female between ages 19 and 49. ☐ Male between ages 12 and 29. ☐ History of myocarditis or pericarditis. ☐ History of treatment with monoclonal antibodies or convalescent serum. ☐ Diagnosed with Multisystem Inflammatry Syndrome (MIS-C or MIS-A) after a COVID-19 infection.	☐ Have a weakened immune system (i.e. HIV infection, cancer) or take immunosuppressive drugs. ☐ Have a bleeding disorder ☐ Take a blood thinner ☐ History of heparin-induced thrombocytopenia (HIT)	☐ Currently pregnant or breastfeeding ☐ Have received dermal fillers

Third or Booster Dose Eligibility: ☐ 65 yrs or older ☐ Individual in long term care settings ☐ Immunocompromised

☐ 18-64 yrs with a medical condition, occupation, or institutional setting that increases the risk of COVID-19 exposure, transmission, or severity

☐ **I attest that I am eligible for a COVID-19 third dose or booster dose.**

Please read and sign the top of the next page.

Informed Consent - Please read and sign if you agree.

My signature below indicates that:

- **I have voluntarily chosen to receive the vaccination and consent to the administration.**
- **I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient or am authorized to consent on behalf of the client.**
- **I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization ("EUA") provided for the vaccine(s) to be administered.**
- **I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.**
- **I understand the benefits and risks of the vaccine(s).**
- **I will immediately alert the provider of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine.**
- **I understand I should remain in the area for 15 minutes after the vaccination for observation or 30 minutes if I have any history of severe allergic reaction or anaphylaxis.**

_____ _____

Participant/Guardian/Authorized Representative Signature Date

OFFICE USE ONLY

Vaccine (CVX)	**Dose #**	**VFC/AVAP**	**Admin Site**	**Lot #**	**Manufacturer**	**EUA/VIS Date**
☐ **Pfizer-BioNTech COVID-19 vaccine 0.3mL**(208)		V07			**PFR**	
☐ **Moderna COVID-19 vaccine 0.5 mL** (207)		V07			**MOD**	
☐ **Janssen COVID-19 vaccine 0.5 mL** (212)		V07			**JSN**	
☐						
☐						
☐						

☐ Refer to _____ for _____

☐ Adverse Event _____ ☐ VAERS Report completed_____

☐ _____

Provider name (print) _____

Provider name (signature) _____

Event Location _____

Agency _____

Name _____ **Arrival Time** _____

Birth Date_____ **Exit Time** _____

Date_____

Administration Sites	
Left Deltoid IM	LDI
Right Deltoid IM	RDI