COVID-19 Vaccination Screening and Consent under Emergency Use Authorization

PATIENT DEMOGRAPHIC INFORMATION

Last Name:	First Name:	Middle Initial:
Date of Birth: / /	Sex: Male ☐ Female ☐ Other ☐	
Race: White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan Native ☐ None Specified ☐ Refused ☐	Hispanic Ethnicity: Yes ☐ No ☐ Unknown ☐ Refused ☐	
Address:	City:	
State:	Home Phone:	Cell Phone:
Zip Code:	Social Security Number#	
☐ Private or employer insurance	☐ Underinsured ☐ Uninsured	☐ Medicare ☐ Medicaid

	HEALTH HISTORY	YES	NO	UNKNOWN
1.	Are you feeling sick today?	☐	☐	☐
2.	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or Epi Pen or had to go to the hospital?	☐	☐	☐
3.	Are you breastfeeding or pregnant?	☐	☐	☐
4.	Have you ever had a serious reaction after any vaccination or injectable medication including a previous dose of the COVID-19 vaccine?	☐	☐	☐
5.	In the past 14 days have you had contact with a confirmed COVID-19 patient	☐	☐	☐
6.	Do you have a history of using dermal fillers	☐	☐	☐
7.	Do you have a history of Multisystem Inflammatory Syndrome? (MIS-C or MIS-A)?	☐	☐	☐
8.	Have you ever been diagnosed with Heparin Induced Thrombocytopenia (HIT)?	☐	☐	☐
9.	Have you received passive antibody therapy as a treatment for COVID-19	☐	☐	☐
10.	Are you immunocompromised? *(taking medication or being treated for cancer, leukemia, HIVAIDS or other immune system problems or taking medication that affects your immune system)*	☐	☐	☐
11.	Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
12.	Have you ever received a dose of COVID-19 vaccine? If so, Date received_____	☐	☐	☐

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 or https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/moderna-covid-19-vaccine or https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/janssen-covid-19-vaccine

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that I have been advised of the Missouri Department of Health and Senior Services' Notice of Privacy Practices and where I can obtain any revisions made to this Notice. **https://health.mo.gov/information/hipaa/pdf/DHSSNoticeofPrivacyPolicies.pdf**

PRINT NAME of Patient or Legal Guardian (for patients under the age of 18)		
SIGNATURE OF Patient or Legal Guardian	**RELATIONSHIP TO CLIENT**	**TODAY'S DATE**

For Clinic Use only

Manufacturer: **Brand:** **Lot Number:** **Exp Date: __/__/__** **Dose number:** 1 ☐ or 2 ☐	**Injection Site (Deltoid)** **L ☐ R ☐** **Vaccine Dose _____mL**	**Date Administered & EUA fact sheet given ____/____/____** EUA Date Jansen: 7/28/2021 EUA Date Pfizer: 8/12/2021 EUA Date Moderna: 8/12/2021
Administered by Name & Title : **☐ Gail Vaughn, RPh ☐_____** **☐ Kendra White, PharmD.**	**Signature: X_____**	
Agency & Address: Hometown Pharmacy 606 E. Mount Vernon Blvd, Mount Vernon, MO 65712		
Clinic administration address: 606 E. Mount Vernon Blvd, Mount Vernon, MO 65712		

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Information for healthcare Professionals about the health history for COVID-19 vaccines

Are you feeling sick today? There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (e.g., upper respiratory infections, diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics. Vaccination of persons with current SARS-CoV-2 infection should be deferred until the person has recovered from acute illness and they can discontinue isolation. While there is no minimum interval between infection and vaccination, current evidence suggests reinfection is uncommon in the 90 days after initial infection. Persons with documented acute SARSCoV-2 infection in the preceding 90 days may delay vaccination until near the end of this period, if desired.

Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital? Allergic reactions, including severe allergic reactions, NOT related to vaccines or injectable therapies (e.g., food, pet, venom, environmental, or latex allergies; oral medications) are NOT a contraindication or precaution to vaccination with currently authorized COVID-19 vaccine. HOWEVER, individuals who have had severe allergic reactions to something, regardless of cause, should be observed for 30 minutes after vaccination. All other persons should be observed for 15 minutes.

Have you ever had a serious reaction after any vaccination or injectable mediation including a previous dose of the COVID-19 vaccine? History of severe allergic reaction (e.g., anaphylaxis) to a previous dose or component of the COVID-19 vaccine product being offered is a contraindication to that COVID-19 vaccine. If the patient answers Yes to this question, defer vaccination for 90 days from date of therapy.

In the past 14 days have you had contact with a confirmed COVID-19 patient? Wait until 14 days after quarantine period ends if the contact was in an outpatient or community setting. If person is a resident in a congregate healthcare or other congregate setting go ahead and vaccinate

Are you breastfeeding or pregnant? Is not a contraindication to current COVID-19 vaccination. While there are currently no available data on the safety of COVID-19 vaccines in pregnant people, studies and results are expected soon. Pregnant people may choose to get vaccinated. Observational data demonstrate that while the absolute risk is low, pregnant people with COVID-19 have an increased risk of severe illness. Breastfeeding is not a contraindication to current COVID-19 vaccine. Lactating people may choose to be vaccinated. There is no data available for lactating people on the effects of mRNA vaccines.

Have you received passive antibody therapy as a treatment for COVID-19? Based on the estimated half-life of monoclonal antibodies or convalescent plasma as part of COVID-19 treatment, as well as evidence suggesting that reinfection is uncommon in the 90 days after initial infection, vaccination should be deferred for at least 90 days, as a precautionary measure until additional information becomes available, to avoid interference of the antibody treatment with vaccine-induced immune responses

Are you immunocompromised? ***(taking mediation or being treated for cancer, leukemia, HIV/AIDS or other immune system problems or taking medication that affects your immune system*** is not a contraindication to current COVID-19 vaccine, including those with cancer, leukemia, HIV/AIDS and other immune system problems or taking medication that affects their immune systems. However, patients should be informed that the vaccine might be less effective than in someone who is immunocompetent.

Do you have a bleeding disorder or are you taking a blood thinner? COVID-19 vaccine may be given to these patients, if a physician familiar with the patient's bleeding risk determines that the vaccine can be administered intramuscularly with reasonable safety. ACIP recommends the following technique for intramuscular vaccination in patients with bleeding disorders or taking blood thinners: a fine-gauge needle (23-gauge or smaller caliber) should be used for the vaccination, followed by firm pressure on the site, without rubbing, for at least 2 minutes.

Name: _____ Date of Birth: _____

This attestation form is used to verify your eligibility to receive an additional dose of COVID-19 vaccine.

Which COVID-19 vaccine did you receive previously:

☐ Pfizer-BioNTech COVID-19 Vaccine Date of first dose ____/____/____
☐ Moderna COVID-19 Vaccine Date of second dose ____/____/____

Additional doses are recommended at least 28 days after the date of the second dose.

Currently, CDC is recommending that moderately to severely immunocompromised people receive an additional dose. This includes people who have:

- Been receiving active cancer treatment for tumors or cancers of the blood
- Received an organ transplant and are taking medicine to suppress the immune system
- Received a stem cell transplant within the last 2 years or are taking medicine to suppress the 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 your immune response

I attest that I meet one or more of the criteria listed above.

Signature of patient, parent or legal guardian: _____

Printed name: _____ Relationship: _____

Date: _____

PHARMACIST: This consent form may not satisfy the consent requirements of your particular state. Additional information, documentation and/or counseling may be required under your state's laws. You are responsible for ensuring that all requirements for consent for a minor to receive a COVID-19 vaccination are met.

Consent for Pfizer-BioNTech COVID-19 Vaccination of Minor

Child's Name (Last, First, MI) | Date of Birth (mm/dd/yyyy) | Age

The Food and Drug Administration (FDA) has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine to prevent COVID-19 in individuals 12 years of age and older under an Emergency Use Authorization (El-JA). The Pfizer-BioNTech COVID-19 Vaccine "Fact Sheet for Recipients and Caregivers" is available at https://www.fda.gov/media/144414/download. I understand the risks and potential side effects of the Pfizer-BioNTech COVID-19 Vaccine. I understand that the PfizerBioNTech COVID-19 Vaccine is administered as a 2-dose series and the minor named above will need to receive a second dose approximately 3 weeks apart.

CONSENT:

- I have reviewed this consent form, and I understand that information available from the Centers for Disease Control and Prevention (CDC), including the "Fact Sheet for Recipients and Caregivers," includes more detailed information about the potential risks and benefits of the Pfizer-BioNTech COVID-19 Vaccine.
- I have the legal authority to consent to have the child named above vaccinated with the Pfizer-BioNTech COVID-19 Vaccine.
- If permitted under state law, I consent to the child receiving the Pfizer-BioNTech COVID-19 Vaccine whether or not I am present at the vaccination appointment.
- If I have health insurance that covers the child named above, I give permission for my insurance company to be billed for the costs of administering the Pfizer- BioNTech COVID-19 Vaccine.
- I understand that all immunizations will be reported to the state Immunization Information System (IIS) and the CDC.

I GIVE CONSENT for the child named at the top of this form to get vaccinated with the Pfizer-BioNTech COVID-19 Vaccine.

Signature of Legally Authorized Representative | Date

Printed Name | Relationship

Street Address | City | State | Zip

Phone Number (please provide best contact number)