WFMC HEALTH COVID-19 VACCINE SCREENING AND CONSENT FORM

SECTION 1: INFORMATION ABOUT YOU (PLEASE PRINT)

Last Name	**First Name**	**Middle Name**
Date of Birth	**Phone Number**	**Gender M / F / X**
Mailing Address		
City	**State**	**Zip code**

SECTION 2: INSURANCE POLICY INFORMATION – Primary Coverage

Insurance Name	**Policy Holder ID#**	**Group #**
Name of Insurance Policy Holder		
Date of Birth of Policy Holder	**Employer of Policy Holder**	**Gender M / F / X**
Relationship to Patient		

SECTION 3: COVID-19 SCREENING QUESTIONS

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.

#	Screening Questions	Yes	No	Don't Know
1.	Are you feeling sick today?	☐	☐	☐
2.	Have you received a dose of COVID-19 vaccine? ☐ Pfizer ☐ Moderna ☐ Jannssen (Johnson and Johnson) ☐ Other _____			
3.	Have you ever had a severe 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including Wheezing.)			
	• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
	• Polysorbate	☐	☐	☐
	• 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	☐
5.	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	☐	☐	☐
6.	Have you received another vaccine in the last 14 days	☐	☐	☐

7.	Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
8.	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
9.	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
10.	Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
11.	Are you pregnant or breastfeeding?	☐	☐	☐

SECTION 4: PATIENT DEMOGRAPHIC INFORMATION

Race

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian
☐ Other Pacific Islander ☐ Other Race _____

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Primary Language

☐ English ☐ Spanish ☐ Russian ☐ Other _____

SECTION 5: CONSENT FOR COVID-19 VACCINE

- I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the patient and confirm that the patient is at least 16 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to Salem Health Hospitals and Clinics or its agents to administer the COVID-19 vaccine.
- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 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.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless WFMC Health and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.

Signature of Patient or Authorized Representative: _____ Date: _____

Print Name: _____

FOR SITE LOCATION USE ONLY

DOSE	Site (LD/RD)	Route	Manufacturer	Lot #	Expiration Date	Administered By
☐ Dose 1		IM	Pfizer ◯ Moderna ◯			
☐ Dose 2		IM	Pfizer ◯ Moderna ◯			