



COVID-19 VACCINE SCREENING AND CONSENT FORM

SECTION 1: INFORMATION ABOUT PATIENT (PLEASE PRINT)

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|---|--|------------------|---|---|--------------------------------------|----------------------------------|--------------------------------|---|---|--|--|--------------------------------|---|--|--|--|--|---|--|--|--|---|--|--|--|----------------------------------|
| Name: Last: _____ First: _____ Middle Initial: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Birth: Month _____ Day _____ Year _____ Mobile Phone Number (Patient or Guardian): (_____) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: _____ Apt/Room #: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City: _____ State: _____ Zip: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Legal Guardian: Last: _____ First: _____ Middle Initial: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sex (Gender assigned at birth) <input type="checkbox"/> Female <input type="checkbox"/> Male | <table border="0" style="width: 100%;"> <tr> <td colspan="3">Race</td> <td>Ethnicity</td> </tr> <tr> <td><input type="checkbox"/> American Indian or Alaska Native</td> <td><input type="checkbox"/> Native Hawaiian or other</td> <td><input type="checkbox"/> Other Asian</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Asian</td> <td><input type="checkbox"/> Pacific Islander</td> <td colspan="2"><input type="checkbox"/> Other Nonwhite</td> </tr> <tr> <td><input type="checkbox"/> Black or African American</td> <td><input type="checkbox"/> White</td> <td colspan="2"><input type="checkbox"/> Other Pacific Islander</td> </tr> <tr> <td colspan="3"></td> <td><input type="checkbox"/> Hispanic or Latino</td> </tr> <tr> <td colspan="3"></td> <td><input type="checkbox"/> Not Hispanic or Latino</td> </tr> <tr> <td colspan="3"></td> <td><input type="checkbox"/> Unknown</td> </tr> </table> | Race | | | Ethnicity | <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or other | <input type="checkbox"/> Other Asian | <input type="checkbox"/> Unknown | <input type="checkbox"/> Asian | <input type="checkbox"/> Pacific Islander | <input type="checkbox"/> Other Nonwhite | | <input type="checkbox"/> Black or African American | <input type="checkbox"/> White | <input type="checkbox"/> Other Pacific Islander | | | | | <input type="checkbox"/> Hispanic or Latino | | | | <input type="checkbox"/> Not Hispanic or Latino | | | | <input type="checkbox"/> Unknown |
| Race | | | Ethnicity | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or other | <input type="checkbox"/> Other Asian | <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Pacific Islander | <input type="checkbox"/> Other Nonwhite | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> White | <input type="checkbox"/> Other Pacific Islander | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | <input type="checkbox"/> Hispanic or Latino | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | <input type="checkbox"/> Not Hispanic or Latino | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Insurance Carrier ID #: _____ Grp #: _____ Insurance Company : _____ Insurance Company Phone # _____ Insured's Name: _____ Relationship: _____ Insured's Date of Birth _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Secondary Insurance Carrier ID #: _____ Grp #: _____ Insurance Company : _____ Insurance Company Phone # _____ Insured's Name: _____ Relationship: _____ Insured's Date of Birth _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is this the patient's first or second dose of the COVID-19 vaccination? <input type="checkbox"/> First Dose <input type="checkbox"/> Second Dose | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

SECTION 2: COVID-19 SCREENING QUESTIONS

| Please check YES or No for each question. | Yes | No |
|--|-----|----|
| 1. Do you have today or have you had at any time in the last 10 days a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea? | | |
| 2. Have you tested positive for and/or been diagnosed with COVID-19 infection within the last 10 days? | | |
| 3. Have you had a severe allergic reaction (e.g. needed epinephrine or hospital care) to a previous dose of this vaccine or to any of the ingredients of this vaccine? | | |
| 4. Have you had any other vaccinations in the last 14 days (e.g. influenza vaccine, etc.)? | | |
| 5. Have you had any COVID-19 Antibody therapy within the last 90 days (e.g. Regeneron, Bamlanivimab, COVID Convalescent Plasma, etc.) | | |

SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE

| Please check YES or No for each question. | Yes | No |
|--|-----|----|
| 6. Do you carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, foods, vaccines or latex? | | |
| 7. For women, are you pregnant or is there a chance you could become pregnant? | | |
| 8. For women, are you currently breastfeeding? | | |
| 9. Are you immunocompromised or on a medication that affects your immune system? | | |
| 10. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication? | | |
| 11. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive: | | |

- I certify that I am: (a) the patient and at least 16 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 16 years of age; or (c) legally authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the healthcare providers at Kids First Pediatrics 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 either 16 years of age or older or 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 (or more in specific cases) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Kids First Pediatrics, 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.
- I authorize Kids First Pediatrics or its agents to submit a claim to my insurance provider for administration of the COVID-19 vaccine. I understand that I will have no out-of-pocket cost or cost sharing associated with receiving the vaccine.
- **I Understand that the COVID-19 vaccine received today requires two (2) doses from the same manufacturer to be fully effective. I understand that I must return within the prescribed number of days (17-21 days) after the first dose to receive a second dose of the vaccine. If more than the prescribed number of days have elapsed since the first dose, the second dose should be given at the earliest opportunity.**

Signature of Patient or Authorized Representative _____ Date: _____

Print Name of Representative and Relationship to Person Receiving Vaccine: _____

| Site (LD/RD) | Route | Manufacturer (MVX) | Lot # Unit of Use/ Unit of Sale | Expiration Date | Date of EUA Fact Sheet |
|--------------|-------|--------------------|---------------------------------------|-----------------|------------------------|
| | IM | PFIZER | | | |

| | |
|--|--|
| Administered at location: facility name/ID | |
| Administered at location: Type | |
| Administration Address: | |
| CVX (product) | |
| Sending organization: | |

Vaccinator Print Name: _____ Signature: _____ Date: _____

Vaccine administering provider suffix: _____