Clear Form

HAWAI'I HEALTH SYSTEMS CORPORATION
KAUA'I REGION

Community COVID-19 Vaccine Intake Consent Form (First Dose)

Vaccination Clinic Location: ◯ **KVMH** ◯ **SMMH**

Name: _____ **Date of Birth:** _____
Last **First** **Full Middle**

Race: ◯ Asian ◯ American Indian or Alaska Native ◯ Black or African American
◯ White ◯ Native Hawaiian or Other Pacific Islander

Ethnicity: ◯ Hispanic or Latino ◯ Non-Hispanic ◯ Non-Latino

Medications *(drug name only)*: _____
_____
_____

Relevant Medical Information ***(Circle all that Apply):***

Diabetes Hypertension High Cholesterol Kidney Disease

Heart Disease Cancer Other: _____

COVID -19 Screening Questions	**YES**	**NO**	**DON'T KNOW**
1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?	◯	◯	◯
2. In the past two weeks have you had contact with anyone who tested positive for COVID-19?	◯	◯	◯
3. Have you had any new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?	◯	◯	◯

To be filled out by the Immunizer: Patient Temperature: **Date:**

If patient answers yes to any of these questions or patient's bodily temperature is 100º F or greater, please inform them that they should not receive the vaccine at this time. Instruct them to contact their primary care provider for next steps.

Immunization Screening Questions	YES	NO	DON'T KNOW
1. Are you sick today? (For example: a cold, fever or acute illness)	○	○	○
2. Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.)	○	○	○
3. Have you ever had a serious reaction after receive a vaccination? Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare provider professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	○	○	○
4. Have you had a seizure or a brain or other nervous system problem or Buillain Barre?	○	○	○
5. Do you take anticoagulation medication? (For example: Warfarin, Coumadin or other blood thinner)	○	○	○
6. Do you have a long-term health problem such as heart disease, lung, disease, liver disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorder?	○	○	○
7. Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease or any other immune system problem?	○	○	○
8. Do you have a weakened immune system or in the past 3 months taken medications that weaken it such as cortisone, prednisone, other steroids, anticancer drugs or radiation treatments?	○	○	○
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	○	○	○
10. For women, are you pregnant or is there a chance you could become pregnant during the next month?	○	○	○
11. Have you received any vaccinations (i.e. flu) or TB skin test in the past 4 weeks?	○	○	○

CONSENT FOR SERVICES: I/my caregiver have been provided with a fact sheet corresponding to the COVID vaccine that I am receiving. I/my caregiver have read the information provided about the vaccine I am to receive. I/my caregiver have had the chance to ask questions that were answered to my satisfaction. I/my caregiver understand the benefits and risks of vaccination and I voluntarily consent to vaccination and assume full responsibility for any reactions that may result. I/my caregiver understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I/my caregiver understand if I experience side effects after leaving that I should do the following as needed: contact my doctor or call 911. I/my caregiver request that the vaccine be given to me.

X _____ / /

Signature of vaccine recipient or their caregiver indicates acceptance to receive vaccine Date