**Community COVID Vaccine Intake Consent Form** (First Dose)

**Vaccination Clinic Location: KVMH SMMH**

F M

/ /

First Name Middle Name Last Name Date of Birth Gender

Street Address City State Zip Code

Phone Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: Asian American Indian or Alaska Native Black or African American

Native Hawaiian or Other Pacific Islander White

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

Insurance Provider Group Number Policy Number

Medications *(drug name only)*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Relevant Medical Information *(Circle All that Apply)*: Diabetes - Hypertension - High Cholesterol - Kidney Disease - Heart Disease - Cancer

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DON’T COVID -19 Screening Questions YES NO KNOW**

1. Have you had a POSITIVE COVID-19 test result / diagnosis in the last

90-days?

If you answered yes to #1:

1. Have you received monoclonal antibodies for COVID-19 in the past

90-days?

1. Have you received convalescent plasma for COVID-19 in the past

90-days?

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

*Vaccination Time:\_\_\_\_\_\_\_\_\_\_\_ ❑ L Arm ❑ R Arm Lot # \_\_\_\_\_\_\_ RN Initials:\_\_\_\_\_\_\_\_*

**If patient’s bodily temperature is 100⁰ 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.**

**For Vaccine Recipients:**

*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.*

**DON’T**

**Immunization Screening Questions YES NO KNOW**

1. Are you sick today? (For example: a cold, fever or acute illness)

1. Have you received any vaccine (i.e. flu) or a TB skin test in the past 14-days?

1. Are you allergic to polyethylene glycol (PEG) or polysorbate?

1. Have you ever had a serious reaction after receiving a vaccination?

1. Has any physician or other healthcare provider ever cautioned or warned

you about receiving certain vaccines or receiving vaccines outside of a

medical setting?

1. Do you have a bleeding disorder or are you taking a blood thinner?
2. Do you have a weakened immune system caused by something such as

HIV infection or cancer or do you take immunosuppressive drugs or therapies?

1. For women, are you pregnant or is there a chance you could become

pregnant during the next month?

**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 l 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