

COVID-19 Immunization Screening and Consent Form

Additional Dose for Moderately to Severely Immunocompromised

Updated: January 6, 2022

Reci	pient Name (please print)	Preferred Name						
DOE	Indicate ID Below: TM — Trai	oman/Girl TW – Transgender Woman/Girl M – Man/Boy Transgender Man/Boy NB – Non-Binary Person GNC – Gender Non-Conforming t Sure/Questioning NR – Chose not to Respond Gender not Listed (write-in)						
		Pronouns: write-in by client's nam	е					
Indi	Sex Assigned at Birth Key: Marital Status Key:						– Married Unknown	
Add	ress City	State Zip	Email Addres	SS				
	ent/Guardian/ Surrogate (if applicable, please print		Preferred La	nguage				
	Ethnicity Key: DECL – Declined HIS – Hispanic Origin NHL – Non-Hispanic Origin UNK - Unknown	Race Race Key: Indicate Race Below: AIA – Native American or Alaskan ASN – Asian BAA – African American or Black DECL – Declined NHP – Native Hawaiian or Pacific Islander WHT – White OTH – Other or Multiracial						
Prim	nary Insurance Name	·			criber Relation atient			
Prim	nary Insurance Address	Primary Insurance Group # Primary Insurance Phone #						
Seco	ondary Insurance Name	Secondary Insurance ID#	ndary Insurance ID# Subscriber Name/DOB Subscriber F to Patient			criber Relation atient		
Seco	ondary Insurance Address	Secondary Insurance Group # Secondary Insurance Phone #						
Clinic/Office Site Where Vaccine is Administered Primary Care Physician Address/Phone Number								
	Scre	ening Questionnaire						
1.	Will you be under the age of 5 years old for the Pfiz Moderna vaccine, on the day of your appointment		r the	□ Yes		No		
2.	Are you feeling sick today?			□ Yes		No		
3.	. In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a health care provider or health department to isolate orquarantine at home due to COVID-19 infection or exposure?					No	□ Unknown	
4.	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? If yes, when did you receive the last dose? Date:					No	□ Unknown	
5.	5. Have you ever had an immediate allergic reaction (e.g., hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injection, or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything?					No	□ Unknown	
6.	6. Are you pregnant or considering becoming pregnant?					No	□ Unknown	

7.	Are you moderately or severely immunocompromised due to one or more of the medical conditions or receipt of immunosuppressive medications or treatments listed below?		Yes	No	□ Unknown	
	1) Active treatment for solid tumor and hematologic malignancies, 2) Receipt of solid-organ transplant and taking immunosuppressive therapy, 3) Receipt of CAR-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy), 4) Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome), 5) Advanced or untreated HIV infection, 6) Active treatment with high-dose corticosteroids (i.e., 8805;20mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory					
8.	Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?		Yes	No	□ Unknown	
9.	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?		Yes	No	□ Unknown	
10.	Have you received 2 previous doses of the Pfizer or Moderna COVID-19 vaccine, and was your last dose at least 28 days ago?		Yes	No	Date:	
					(if applicable)	
11.	Have you received a previous dose of the Janssen/Johnson & Johnson COVID-19 vaccine?		Yes	No		
12.	Have you received a previous dose or doses of a non-FDA authorized or approved COVID-19 vaccine (AstraZeneca – VAXZEVRIA, Sinovac – CORONAVAC, Serum Institute of India –		Yes	No	Date(s):	
	COVISHIELD, Sinopharm/BIBP, COVAXIN, Novavax – Covovax or Nuvaxovid)?				(if applicable)	

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not undergone the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available is based on the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks. Please note: FDA approved the Pfizer-BioNTech COVID-19 vaccine as a two-dose series in individuals 16 years of age and older. The vaccine continues to be available under an EUA for certain populations, including for those individuals 5 through 15 years of age and for the administration of a third dose in the populations set forth in the consent section below.

Emergency Use Instruction

Emergency Use Instructions (EUIs) are issued by the CDC to provide information about emergency use of FDA-approved medical products that may not be included in or differ in some way from the information provided in the FDA-approved labeling (package insert). The COVID-19 vaccine by Pfizer-BioNTech is an FDA-approved COVID-19 vaccine (brand name Comirnaty, mRNA) to prevent COVID-19 in persons 16 years of age and older. CDC is issuing EUI to provide information about use of this vaccine as an additional primary dose in certain immunocompromised persons (12 years of age and older) and a booster dose in certain adults (18 years of age and older) who received certain non-FDA authorized or approved COVID-19 vaccine (e.g., certain vaccines available outside of the United States or from clinical trial participation).

Consent

I hereby certify under penalty of law that I am of an age and, if applicable, immunocompromised (e.g., moderate to severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments) as authorized by an EUA or in accordance with an EUI, as applicable, to receive this vaccine, or, the person for whom I am legally authorized to make health care decisions is of an age and, if applicable, immunocompromised as authorized by an EUA or in accordance with an EUI, as applicable, to receive this vaccine. I have had a chance to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health plan, Medicare or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

¹ As set forth in <u>CDC's Emergency Use Instruction (EUI)</u>, "a non-FDA authorized or approved COVID-19 vaccine includes such vaccines "listed for emergency use by the World Health Organization, or is included in CDC's Technical Instructions for Implementing Presidential Proclamation Advancing Safe Resumption of Global Travel During the COVID-19 Pandemic and CDC's Order, or that is a non-placebo part of a clinical trial within or outside the United States that is a WHO-EUL COVID-19 vaccine or a vaccine that is not listed for emergency use by WHO but for which a U.S. data and safety monitoring board or equivalent has independently confirmed efficacy in the United States (hereinafter 'non-FDA authorized or approved COVID-19 vaccines')."

Recipient/Surrogate/Guarecipient) Date / Time	Print N	Name	Relationship to Patient (if other than recipient)				
Telephonic Interpreter's OR	Date / Time							
Signature: Interpreter	Date/ Time	Print: I	Interpreter's Name and	Relationship to Patient				
Area Below to be Completed by Vaccinator								
Which vaccine is the patient receiving today?								
Vaccine Name		Administration		EUA Fact Sheet Da	te Manufacturer & Lot Number			
Pfizer/ BioNTech	□ First Dose	□ Second Dose	☐ Third Dose					
Moderna	□ First Dose	□ Second Dose	☐ Third Dose					
Administration Site	□ Le	eft Deltoid 🗆	Right Deltoid	□ Left Thigh	□ Right Thigh			
Dosage								
Use of this form is optional.					Updated January 6, 2022			