PROVIDER COVID-19 IMMUNIZATION CONSENT FORM

For COVID-19 Provider use only Clinic Name/Code: ____
Location type: (clinic, health department, pharmacy, etc.,)____
Address:________________________City:____________________County:________________________
State:_________________________ Zip Code: _______________ Date of Service:___________________

Person Receiving Vaccine:
(Legal) First Name: ___________________MI: _______ Last Name:_____________________
Date of Birth: ______/______/__________

1. **MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. If you answer "YES" you may not be able to receive the COVID-19 vaccine.**

If YES refer to following websites at www.PfizerMedInfo.com. Moderna www.modernatx.com. Janssen www.janssencovid19vaccine.com. Refer to Pre-vaccination Checklist for COVID-19 vaccines to clarify questions: www.cdc.gov/vaccines/covid-19/downloads/pre-vaccination-screening-form.pdf.	*YES	NO
Have you had a previous COVID-19 vaccine? If yes, what type and date?		
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?		
Have you ever had an allergic reaction to a COVID-19 vaccine or a COVID-19 vaccine component (including polyethylene glycol [PEG], which is found in some medications, or laxatives, and preparations for colonoscopy; or polysorbate, which is found in some vaccines, coated tablets, or IV steroids)?		
Have you ever had an allergic reaction that caused hives, swelling, respiratory distress (including wheezing) or anaphylaxis to a vaccine other than COVID-19 vaccine or an injectable medication that required treatment with epinephrine (EpiPen) or treatment at a hospital? Severe reaction or anaphylaxis to food, pet, venom, environmental, or oral medication allergies are not contraindications or precautions to vaccination with any COVID-19 vaccine.		
Do you have a bleeding disorder or are you taking a blood thinner?		
Have you received a hematopoietic cell transplant (HCT) or CAR-T-cell therapy since receiving COVID-19 vaccine? You should be revaccinated with a primary vaccine series at least 12 weeks after transplant or CAR-T-cell therapy.		
Did you develop myocarditis or pericarditis after the first dose of COVID-19 vaccine? Do you have history of myocarditis or pericarditis prior to COVID-19 vaccination? Are you a male between age 12 through 29 years?		
Are you pregnant, or planning to become pregnant? Pregnant, breastfeeding, and post-partum people 18 through 49 years of age should be aware of the rare risk of thrombosis with thrombocytopenia syndrome (TTS) after the Janssen COVID-19 vaccine and the availability of other FDA authorized or approved COVID-19 vaccines.		
Are you immunocompromised? Do you have a condition that weakens your immune system? Are you receiving any immunosuppressive therapy? You are eligible to receive any FDA-authorized or FDA-approved COVID-19 vaccine unless you have a contraindication for some other reason. However, you will need special counseling about the vaccine.		
Have you had history of heparin-induced thrombocytopenia (HIT) or thrombosis with thrombocytopenia syndrome (TTS)? If it has been 90 days or less since TTS resolved, you may receive Pfizer-BioNTech or Moderna COVID-19 vaccine. After 90 days since TTS resolved, you may receive any FDA-authorized or FDA-approved COVID-19 vaccine. People who developed TTS after their initial Janssen vaccine should not receive a Janssen booster dose.		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment or for post-exposure prophylaxis (PEP)? Defer vaccination 90 days after treatment and defer 30 days after PEP.		
Have you had Multisystem Inflammatory Syndrome (MIS)? Defer vaccination for at least 90 days. The decision for COVID-19 vaccination should be between the patient, their guardian, clinical team, or a specialist.		
Have you had history of Guillain Barre Syndrome (GBS)? People with a history of GBS can receive any FDA-authorized or approved COVID-19 vaccine. People who had GBS after receiving Janssen vaccine should be made aware of the option to receive a Pfizer-BioNTech or Moderna COVID-19 vaccine booster at least 8 weeks after the Janssen dose.		

NOTE: Recipients of Janssen COVID-19 vaccine should seek immediate medical attention if they develop shortness of breath, chest pain, leg pain or swelling, persistent abdominal pain, neurological symptoms (including severe or persistent headaches or blurred vision), nausea, vomiting, petechiae, or easy bleeding beyond the vaccination site within 4 to 30 days of receipt of Janssen vaccine.

NOTE: A second dose of COVID-19 vaccine **may** be due in 21 days or 28 days after initial vaccine. Refer to your COVID-19 vaccination record card for proof of initial vaccine date and for second dose due date. Contact your vaccination provider, PCP, or your ADH Local Health Unit in 21 days or 28 days for more information. Janssen COVID-19 vaccine is a ONE dose series.

2. **RELEASE AND ASSIGNMENT:**

Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right.

Please sign here

My signature below indicates I have read, understand, and agree to section **2. Release and Assignment** of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).

Signature of Patient/Parent/Guardian:

___________________________Date_______________

RELEASE AND ASSIGNMENT:

- I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient EUA Fact Sheet for Pfizer COVID-19 vaccine, Moderna COVID-19 vaccine, or Janssen COVID-19 vaccine visit https://www.cdc.gov/vaccines/covid-19/eua/index.html or visit your Local Health Unit or PCP to receive a printed copy of the EUA Fact Sheet.
- I give consent to this COVID-19 provider/staff for the individual named below to be vaccinated with COVID-19 vaccine.
- I hereby acknowledge that I have reviewed a copy of the Provider's Privacy Notice.
- I understand that information about this COVID-19 vaccination will be included in (WebIZ) Arkansas Immunization Information System.

To My Insurance Carrier(s):

- I authorize the release of any medical information necessary to process my insurance claim(s).
- I authorize and request payment of medical benefits directly to this COVID-19 Provider.
- I agree that the authorization will cover all medical services rendered until I revoke the authorization.
- I agree that the photocopy of this form may be used instead of the original.

PATIENT INFORMATION:

(Legal) First Name: ______________________________________ **MI:** ____ **Last Name:** ______________________

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ **Gender:** ☐ Male ☐ Female **Phone #:** ____________________

Street Address: _______________________________ **P.O. Box** ___________ **Apt. No.** __________________________

City: ___________________________________ **State:** _______________________ **Zip Code:** ☐☐☐☐☐

Race: ☐ Asian ☐ Black/African American ☐ Native American /Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic

INSURANCE STATUS (Check appropriate box):

Patient's Relationship to Insurance Policy Holder: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

☐ **Medicaid/ARKids Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐ **Medicare Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐ **Insurance Company Name**: ___________________________

Member ID/Policy #: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

REQUIRED POLICY HOLDER INFORMATION:

(Legal) First Name: _________________ **MI:** ____ **Last Name:** ____

Policy Holder Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ **Email Address:** _______________________

Policy Holder's Employer Name: ____

COVID-19 VACCINE ADMINISTRATION (Completed by staff only)

Co-administration of COVID-19 vaccines and other vaccines including flu vaccine. COVID-19 vaccines and other vaccines **may be administered without regard to timing.** This includes simultaneous administration of COVID-19 vaccines and other vaccines during the same visit. Other vaccines can also be administered any time before or after COVID-19 vaccination.

Ultra-cold COVID-19 Vaccine		Frozen COVID-19 Vaccine		Refrigerated COVID-19 Vaccine
☐ Pfizer-BioNTech (Purple Cap) ☐ Pfizer-BioNTech (Orange Cap) ☐ Pfizer-BioNTech (Gray Cap)		☐ Moderna		☐ AstraZeneca ☐ Janssen (Johnson & Johnson) ☐ Novavax-Matrix-M1 ☐ Other COVID-19 Vaccine________
Route	**Site Code**	**Dosage mL**	**MFG Code**	**Lot Number**
☐ **IM**				

MFG Codes: PFR=Pfizer, MOD=Moderna, ASZ=AstraZeneca, JSN=Janssen, NVX=Novavax, MSD=Merck
Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA

Signature and Title of Vaccine Administrator: ____
Date Vaccine Administered: _________ / ________ / _____________

Revised 12/02/21