COVID-19 Vaccine Consent & Questionnaire – Universal

Date	Recipient temperature	Recipient weight

Patient Information			
Name (please print)		Parent/Guardian (if applicable please print)	
DOB	Gender	Preferred Language	
Address		City State Zip	
Phone Number		Email Address	
Ethnicity (circle one) Hispanic Not Hispanic or Latino Unknown Declined			
Race (circle one) American Indian or Alaska Native Asian Native Hawaiian/Other Pacific Islander Black or African American White Other Race Declined			

Screening Questionnaire (circle one)

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.

1. Are you feeling sick today?	Yes	No	
2. Have you ever received a dose of COVID-19 vaccine?	Yes	No	Unknown
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product: _____			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of the COVID-19 vaccine including either of the following:			
• Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	Yes	No	Unknown
• Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.	Yes	No	Unknown
• A previous dose of COVID-19 vaccine	Yes	No	Unknown

4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)	Yes	No	Unknown
5. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	Yes	No	Unknown

Additional CDC Screening Questions
Check all that apply to you:

- ☐ Female between ages 18 and 49 years old
- ☐ Male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ History of Guillain-Barré syndrome (GBS)

Primary Series Vaccine Information

Date of 1st dose	____ / ____ / _____ ☐ Unknown	Vaccine administered: ☐ Pfizer ☐ Moderna ☐ Janssen ☐ Another product: _____
Date of 2nd dose	____ / ____ / _____ ☐ Unknown	Vaccine administered: ☐ Pfizer ☐ Moderna ☐ Another product: _____
Date of 3rd dose*	____ / ____ / _____ ☐ Unknown	Vaccine administered: ☐ Pfizer ☐ Moderna ☐ Another product: _____

*A 3rd primary series dose of the Moderna or Pfizer COVID-19 vaccine is authorized for administration to individuals at least 12 years of age for Pfizer and at least 18 years of age for Moderna, who have undergone solid organ transplantation, or who are diagnosed with conditions that are considered to have an equivalent level of immunocompromise.

3rd Dose Screening Questions for Moderately to Severely Immunocompromised People Pfizer & Moderna

Check all that apply to you:

- ☐ Been receiving active cancer treatment for tumors or cancers of the blood
- ☐ Received an organ transplant and are taking medicine to suppress the immune system
- ☐ Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system
- ☐ Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
- ☐ Advanced or untreated HIV infection
- ☐ Active treatment with high-dose corticosteroids or other drugs (methotrexate, azathioprine, leflunomide, adalimumab, rituximab, tacrolimus, cyclosporine, mycophenolate) that may suppress your immune response

By signing this form, I attest that the information above is accurate to the best of my knowledge, and that it has been at least twenty-eight (28) days since my 2nd COVID vaccine dose.

Sign Here: _____ Date: _____

COVID-19 Vaccine Booster Shot Screening Questions Pfizer, Moderna & Janssen

Check all that apply to you:

COVID-19 vaccine booster shots are available for the following vaccine recipients who completed their primary series:

- ☐ 65 years of age and older
- ☐ Age 18+ who live in long-term care settings
- ☐ Age 18+ who have underlying medical conditions *
- ☐ Age 18+ who work or live in high-risk settings

*The CDC defines underlying medical conditions as cancer, chronic kidney disease, chronic liver disease, chronic lung disease (COPD, asthma, cystic fibrosis, etc.), neurological conditions (dementia, Alzheimer's), diabetes (type 1 or 2), Down syndrome, heart conditions (heart failure, coronary artery disease, hypertension, etc.), HIV infection, immunocompromised state, mental health conditions, overweight & obesity, pregnancy, sickle cell or thalassemia, smoking (current or former), solid organ or blood stem cell transplant, stroke or cerebrovascular disease, substance use disorders or tuberculosis.

By signing this form, I attest that the information above is accurate to the best of my knowledge, and that it has been at least six (6) months since completion of my COVID-19 vaccine primary series for Pfizer or Moderna, OR at least two (2) months since completion of my COVID-19 vaccine primary series for Janssen.

Sign Here: _____ Date: _____

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 a COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Consent for Services

I have been provided with the EUA for the corresponding COVID-19 vaccine(s) that I am receiving. I understand that the Pfizer and Moderna vaccine require two (2) doses, and the Janssen vaccine requires one (1) dose to be administered in order for it to be effective. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction, I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the post vaccine waiting area for at least 15 minutes (30 minutes if necessary) after the vaccination to be monitored for any potential adverse reactions. I understand that if I experience side effects that I should do the following: contact the VNA Health Care or call 911. I request that the vaccine be given to me or to the person for whom I am authorized to make this request.

Disclosure of Records

I understand that VNA Health Care may be required to or may voluntarily disclose all my health information needed to report administration of vaccine and/or other public health purposes, including reporting to applicable vaccine registries.

Consent for Communication

By signing below, I agree to receive future communications from VNA Health Care via email, phone call or text message. If you wish not to receive emails, phone calls or text messages from VNA Health Care.
Please initial here to opt out. _____

_____
Recipient/Guardian Signature

_____
Print Name

_____
Relationship to patient, other than recipient

_____ _____
Date Time

Vaccine Administration
Office Use Only

Vaccine Location (circle one)

VNA-Highland VNA-Indian VNA-Villa VNA-Wing VNA-Mona Kea VNA-Mobile Clinic

VNA-Bensenville VNA-Bolingbrook VNA-Romeoville VNA-Joliet VNA-Offsite Clinic

Primary Series (circle dose)

	Pfizer-BioNTech (Comirnaty) Ages 12+	**Moderna Ages 18+**	**Janssen (Johnson & Johnson) Ages 18+**
First Dose	0.3 mL	0.5 mL	0.5 mL
Second Dose	0.3 mL	0.5 mL	N/A
Third Dose Immunocompromised	0.3 mL	0.5 mL	N/A

Booster Vaccine (circle dose)

	Pfizer-BioNTech (Comirnaty) Ages 12+		**Moderna Ages 18+**		**Janssen (Johnson & Johnson) Ages 18+**	
Primary Series	**Dose**	**Interval**	**Dose**	**Interval**	**Dose**	**Interval**
Pfizer	0.3 mL	6 months	0.25 mL	6 months	0.5 mL	6 months
Moderna	0.3 mL	6 months	0.25 mL	6 months	0.5 mL	6 months
Janssen	0.3 mL	2 months	0.25 mL	2 months	0.5 mL	2 months

Administration Site (circle one) Left Deltoid Right Deltoid

Manufacturer Lot Number: **Expiration Date:**

Vaccine Administrator Signature