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:			
Refer to product-specific Emergency Use Authorization (EUA) fact sheet for COVID-19 providers			
Person Receiving Vaccine:			
(Legal) First Name: MI: Last Name:			
Date of Birth: /			
1 MEDICAL HISTORY. Complete the following questions for the individual receiving the vectors			
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 Pfizer website at www.PfizerMedInfo.com For	· ·	*YES	NO
to www.modernatx.com For Janssen COVID-19 vaccine refer to www.janssencovid19vaccine.com Have you had a previous COVID-19 vaccine? If yes, date?			
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Have you had any vaccines within the previous 14 days? Pfizer-BioNTech, Moderna, or Janssen COVID-19 vaccine should be administered alone with minimal interval of 14 days before or after any other vaccine.			
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 severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component			
(including polyethylene glycol [PEG], or immediate allergic reaction of any severity to polysorbate (due to			
potential cross-reactive hypersensitivity with the vaccine ingredient PEG) or injectable therapy? (including			
Pfizer-BioNTech, Moderna, or Janssen COVID-19 vaccine) Such as difficulty breathing, swelling of your			
face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness.			
Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive Pfizer-			
BioNTech, Moderna, or Janssen COVID-19 vaccine, a discussion with your healthcare provider can help			
make informed decision.			
Are you immunocompromised? Do you have a condition that weakens your immune system? Are you			
receiving any immunosuppressive therapy? You are still eligible to receive Pfizer-BioNTech, Moderna, or			
Janssen COVID-19 vaccine unless you have a contraindication for some other reason. However, you will need special counselling about the vaccine.			
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Pfizer-			
BioNTech, Moderna, or Janssen OVID-19 vaccine should be deferred for at least 90 days to avoid			
interference of treatment with vaccine-induced immune responses.			
NOTE: Depending on vaccine type, 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 second			
PCP or your ADH Local Health Unit in 21 days or 28 days for more information. Keep your COVID-19 vaccination			
record card for your records for proof of initial vaccine date. Janssen COVID-19 vaccine is a ONE dose series.			
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My signature below indicates I have read, understand, and agree to section 2. Release and			
2. RELEASE AND ASSIGNMENT.	Assignment of the COVID-19 Immunization		
Please read the section on the reverse side of this form.	Consent Form and Vaccine Recipient Emergency		
The Providers Privacy Notice is available at the clinic	Use of Authorization Fact Sheet (EUA).		
site or accompanies this form.		•	
Then sign in the box at right.	Ciamatura of Dationt/Danas (10)	andia.a	
Signature of Patient/Parent/Guardian:			
Please sign here			
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 you may also 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: MI: Last Name: (Legal) First Name: Date of Birth: | / | Gender: Male Female Phone #: _____ P.O. Box _____ Apt. No. ____ **Street Address:** State: _____ Zip Code: City: _ 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 #:** REOUIRED 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) Refrigerated COVID-19 Vaccine** <u>Ultra-cold COVID-19 Vaccine</u> Frozen COVID-19 Vaccine AstraZeneca ☐ Janssen (Johnson & Johnson) ☐ Pfizer-BioNTech Moderna Novavax-Matrix-M1 Other COVID-19 Vaccine Route **Site Code** Dosage mL MFG Code Lot Number \prod 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: ____/___ Phase 1A Phase 1B Phase 1C Vaccine 65 years and Older Public Transit ☐ 16-64 years at high-risk ☐ Public Health/Human Service Phase Long Term Care ☐ Correction Congregate Living ☐ Public Safety **Groupings:** Resident ☐ Media Education ☐ Energy (Select the Long Term Care Essential Government ☐ Finance ☐ Shelter/housing option in the Staff ☐ Food and Agriculture ☐ Transportation/Logistics phase for Healthcare Grocery Store/Meal Delivery ☐ Food Service which the Worker ☐House of Worship ☐ Intellectual/Cognitive Disability person First Responder Manufacturing ☐ IT and Communication belongs) Postal/Package Delivery Service Legal