COVID-19 VACCINE DOCUMENTATION / CONSENT FORM

VACCINE CONSENT: I have been given a copy and have read, or have had explained to me, the information in the FACT SHEET FOR RECIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA) regarding the vaccine checked below. I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request and authorize the release of immunization records for the patient below to any school, health department or other healthcare provider. This authorization remains effective until revoked in writing at any time as provided for in the Sedgwick County Notice of Privacy Practices.

ACKNOWLEDGWMENT OF "NOTICE" OF PRIVACY PRACTICES: I acknowledge that a copy of Sedgwick County's Notice of Privacy Practices has been made available to me with the effective date of February 12, 2020

Sedgwick County Health Department will administer the COVID-19 vaccine regardless of the vaccine recipient's ability to pay COVID-19 vaccine administration fees or health plan coverage status. By signing below you agree to all information provided in the first four sections of this form.

- ☐ Pfizer BioNTech COVID-19 Vaccine
- ☐ Moderna COVID-19 Vaccine
- ☐ Janssen (J&J) COVID-19 Vaccine
- ☐ Pfizer BioNTech COVID-19 Booster
- ☐ Moderna COVID-19 Booster
- ☐ Janssen (J&J) COVID-19 Booster

_____

Signature of Client/Client Representative **Date**

☐ Check this box if client is under 18 and parent/guardian provides verbal consent, (Signature not needed for verbal consent.)

Relationship to Client: ☐ Self ☐ Parent ☐ Guardian ☐ Spouse

CLIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Marital Status: _____ Birth Date: _____ Gender: ☐ Female ☐ Male

Please Select All That Apply:

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

Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Other _____

Race: ☐ White ☐ Black / African American ☐ Asian ☐ American Indian or Alaskan Native ☐ Native Hawaiian or other Pacific Islander ☐ Prefer to Self-Identify _____

Street Address: _____ City: _____

County: _____ State: _____ Zip Code: _____ Phone: _____

Are you disabled? ☐ Yes ☐ No

Consent to Contact: ☐ Call ☐ Text ☐ E-mail ☐ Postal Mail

Family/Guardian Information (Required if client is under 18)

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ City: _____

County: _____ State: _____ Zip Code: _____ Phone: _____

The following is to be filled out by staff only

VACCINE	MVX	CVX	LOT #	EXP DATE	DOSE
☐ **COVVM** – Moderna, COVID-19 Vaccine, 100mcg/0.5mL - ☐ **COVVM** – Moderna, COVID-19 Booster, 50mcg/0.25mL -	MOD	207			☐ 1st Dose ☐ 2nd Dose ☐ 3rd Dose ☐ Booster
☐ **Pfizer –** COVID-19 Vaccine, 30 mcg/0.3mL -	PFR	208			☐ 1st Dose ☐ 2nd Dose ☐ 3rd Dose ☐ Booster
☐ **JANSSEN** – J&J, COVID-19 Vaccine, 0.5mL - 5×10^{10} viral particles -	JSN	212			☐ 1st Dose ☐ Booster
☐ **Pfizer** – Pediatric, COVID-19 Vaccine, 10mcg/0.2mL -	PFR	208			☐ 1st Dose ☐ 2nd Dose ☐ 3rd Dose

DATE	TIME	EXT	SITE	ROUTE	OBSERVATION TIME
		☐ Right ☐ Left	☐ Deltoid (*Preferred*) ☐ Vastus Lateralis	Intramuscular (IM)	☐ 15 MINUTES ☐ 30 MINUTES

Signature of Vaccine Administrator **Date**

Printed Name & Title of Vaccine Administrator

Registration Specialist Initials: _____ Data Entry Initials: _____

Prevaccination Checklist for COVID-19 Vaccination

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.

Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19? If yes, which vaccine product(s) did you receive?	☐	☐	

Dose 1	**Dose 2**	**Dose 3**
Date: _____	Date: _____	Date: _____
Manufacturer: _____	Manufacturer: _____	Manufacturer: _____
Lot Number: _____	Lot Number: _____	Lot Number: _____
Admin. Clinic: _____	Admin. Clinic: _____	Admin. Clinic: _____

3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)*	☐	☐	☐
4. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	☐	☐	☐
5. 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 a 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	☐	☐	☐
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
6. 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.)*	☐	☐	☐
7. Check all that apply to you:			

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ Have a history of Guillain-Barré Syndrome (GBS)

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists