LECOM HEALTH
INSTITUTE FOR SUCCESSFUL AGING

Public Health
Prevent. Promote. Protect.

COVID-19 Vaccine Screening and Consent for Covid-19 Vaccine

Adult Initial Series, Third Dose or Bivalent Booster Dose Consent Form

Section 1: Information about you (please print)

Last:	**First**:	**MI**:
DOB:	**Phone Number:**	**S.S. #:**
Address:		**Apt/Room #:**
City:	**State**:	**Zip**:
Email:		
Gender: ☐ Female ☐ Male	**Race:** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other ☐ White ☐ Pacific Islander	**Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Primary Insurance Carrier ID #: ______________________________

Insurance Company: ______________________

Secondary Insurance Carrier ID #: ______________________________

Insurance Company: ______________________

Dose to be received today: ☐ **1st Dose** ☐ **2nd Dose** ☐ **3rd Dose (Immunocompromised)** ☐ **Bivalent Booster Dose**

FOR ADMINISTRATION USE:

Site (LD/RD)	Route	Manufacturer (MVX)	Lot #	Expiration	EUA
	IM				

Administered at location: Facility Name/ID	
Administered at location: Type	
Administration Address:	

Registration
Apply Sticker in this Field

Vaccinator Print Name: ______________________

Vaccinator Signature: ______________________

Immunization Date: ______________

Circle Site (LD/RD)
LD RD

Immunizer
Confirm and Apply Sticker in this Field

Section 2: COVID-19 SCREENING QUESTIONS

Please check YES or NO for each question.	YES	NO
1. Are you sick today?		
2. Have you had in the last 10 days fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?		
3. In the past two weeks, have you tested positive for COVID-19?		
4. Do you have allergies or reactions to any medications, foods, vaccines, or latex?		
5. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?		
6. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
7. Have you had any other vaccinations in the last 14 days?		
8. Have you ever had an allergic reaction to another vaccine or an injectable medication?		
9. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the ingredients of this vaccine? (including Polyethylene Glycol found in some medications or Polysorbate)		
10. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive. Manufacturer: Date 1: Date 2: Date 3: Date 4:		
11. Do you carry an Epi-pen for emergency treatment of anaphylaxis?		
12. For **women**, are you pregnant or is there a chance you could become pregnant or breastfeeding?		

☐ I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Pennsylvania Department of Health (DOH) or its agents to administer the COVID-19 vaccine.

☐ I understand the product has not been approved or licensed by the FDA for certain indications, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 6 months of age and older; (under EUA), and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.

☐ I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

☐ I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.

☐ On behalf of myself, my heirs, and personal representatives, I hereby release and hold harmless the State of Pennsylvania, the Pennsylvania Department of Health (DOH), and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors, and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.

☐ I acknowledge that: (a) I understand the purposes/benefits of Pennsylvania SIIS, Pennsylvania's immunization registry and (b) DOH will include my personal immunization information in Pennsylvania SIIS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.

☐ I further authorize DOH or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to DOH or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if DOH invoices me after the time of service, upon receipt of such invoice.

☐ I acknowledge receipt of the Notice of Privacy Rights.

Print Name: ______________________________ **Date**: ____________________

Signature of Patient or Authorized Representative ______________________________