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| **COVID 19 VACCINE REQUIRED INFORMATION** |
| First Name | Last Name | Date of Birth(mm/dd/yyyy) | Age |
| Street Address | City, State, Zip |
| Email Address | Phone # |
| Insurance Carrier (as appears on your card) | Policy # |
| Subscriber’s Name and DOB (if other than self) | Relationship to Subscriber(if other than self) |
| Race (you may check more than one): | * African American
* Asian
* American Indian/Alaska Native
* Native Hawaiian/Pacific Islander
* White
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | Ethnicity:* Hispanic
* Non-Hispanic
 | Sex:* Male
* Female
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| **COVID 19 PREVACCINATION CHECKLIST** |
| 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 if not clear, please ask your healthcare provider to explain it.  | Yes | No | Don’t Know |
| 1. Are you feeling sick today?
 |  |  |  |
| 1. Have you ever received a dose of COVID-19 vaccine?

If yes, which vaccine product did you receive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 1. Have you ever had an allergic reaction\* to:
 |
| * A component of a COVID-19 vaccine including either of the following:
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| -Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures. |  |  |  |
| -Polysorbate3, which is found in some vaccines, film coated tablets, and intravenous steroids. |  |  |  |
| * A previous dose of COVID-19 vaccine.
 |  |  |  |
| * A vaccine or injectable therapy that contains multiple components,

 one of which is a COVID-19 vaccine component, but is not known which component elicited the immediate reaction. |  |  |  |
| 1. Have you ever had an allergic reaction\* to another vaccine (other than COVID-19 vaccine) or an injectable medication?
 |  |  |  |
| 1. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.
 |  |  |  |
| 1. Have you received any vaccine in the last 14 days?
 |  |  |  |
| 1. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?
 |  |  |  |
| 1. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?
 |  |  |  |
| 1. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?
 |  |  |  |
| 1. Do you have a bleeding disorder or are you taking a blood thinner?
 |  |  |  |
| 1. Are you prone to fainting after shots or blood draws?
 |  |  |  |
| 1. Are you pregnant or breastfeeding?
 |  |  |  |
| 1. Do you have dermal fillers?
 |  |  |  |

\*This would include a severe 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.

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| **COVID-19 VACCINE CONSENT** |
| I consent to administration of the COVID-19 vaccination, and I acknowledge and agree with the following statements:  |
| * The U.S. Food and Drug Administration (FDA) has authorized the emergency use of the COVID-19 vaccines, which are not currently FDA-approved. At this time, there is no FDA approved vaccine to prevent COVID-19.
 |
| * I have received the Emergency Use Authorization (EUA) Fact Sheet for Recipients and Caregivers for the COVID-19 Vaccine (the “Fact Sheet”) and have read it or have had it read to me.
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| * Some versions of the COVID-19 vaccine require two (2) identical doses by the same manufacturer in order to be effective. I understand that I will be informed at the time of vaccination whether I will need a second dose. If a second dose is required, I understand that I am responsible for scheduling an appointment for my second dose in accordance with the timeframe outlined in the Fact Sheet.
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| * I understand the known and potential risks and benefits to the COVID-19 vaccine and the extent to which such benefits and risks are unknown.
 |
| * I acknowledge that I have the option to refuse vaccination and have been informed of any available alternatives to the COVID-19 vaccine and the risks and benefits of available alternatives.
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| * Recipients who are Pregnant or Breastfeeding: Pregnant and breastfeeding persons were not included in the clinical trials for COVID19 vaccines. I have discussed the potential risks of COVID-19 infection versus the risk of vaccination with my healthcare provider and have made the informed decision to receive a COVID-19 vaccine.
 |
| * I understand that it is recommended that I remain at the vaccination clinic for fifteen (15) minutes following administration of the vaccine for observation (the “Monitoring Period”) to ensure I do not experience an adverse reaction. Recipients that have a history of severe allergic reactions should be monitored for thirty (30) minutes post vaccination.
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| * I acknowledge that I have received information on V-safe, a voluntary smartphone-based tool operated by the Centers for Disease Control and Prevention (CDC). Through V-safe, vaccine recipients can report any side effects of the COVID-19 vaccine to the CDC. This information helps CDC monitor the safety of COVID-19 vaccines in near real time.
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| * I authorize Richmond Pediatric Associates to submit a claim to my insurance provider for administration of the COVID-19 vaccine. I understand that I will have **no** out-of-pocket cost or cost sharing associated with receiving the vaccine. I acknowledge I was offered the Notice of Privacy Practices, which is also available at <https://www.richmondpediatrics.com/storage/app/media/HIPAA-Privacy-Practices.pdf>.
 |
| * I have had the opportunity to ask questions which have been answered to my satisfaction.
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**If you experience an adverse reaction to the COVID-19 vaccine, please contact your primary care provider or present to the nearest emergency department. If you are experiencing a medical emergency, call 911.**

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| Signature of Recipient/Authorized Representative: | Date: |
| Print Name: | Relationship to patient,if signed by an authorized representative: |