COVID-19 VACCINE SCREENING & CONSENT FORM

Name: _____ **Birth date**: ____/____/_____ **Age**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Phone: _____ **Sex Assigned At Birth**: ☐ Male ☐ Female **SSN #:** _____

Gender Identity: _____ **Pronouns:** _____

Race (SELECT ONE): ☐ Asian ☐ Black ☐ Native American ☐ Pacific Islander ☐ White ☐ Other

Ethnicity (SELECT ALL THAT APPLY): ☐ Hispanic ☐ Haitian ☐ Non-Hispanic/Non-Haitian

Please indicate below which COVID-19 Vaccine dose you are eligible for AND the manufacturer:

☐ First Dose ☐ Second Dose ☐ Third Dose (4 weeks from 2nd Dose)-**Immunocompromised persons only** ☐ Booster (6 mos from 2nd Dose)	☐ Pfizer ☐ Moderna

COVID SCREENING QUESTIONS

Please check YES or NO for each question.	**Yes**	**No**
1. Do you have today or have you had in the last 10 days a 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?		
2. Have you tested positive for and/or been diagnosed with COVID-19 infection within the last 10 days?		
3. Have you had a severe allergic reaction (i.e. needed epinephrine or hospital care) to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
4. Have you had any COVID-19 Antibody therapy within the last 90 days (i.e. Regenron, Bamlanivimab, COVID Convalescent Plasma, etc.)?		

IMMUNIZATION SCREENING QUESTIONS

1. Do you carry an Epi-Pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, food, vaccines or latex?		
2. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
3. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive?		

If **INSURED**, please complete insurance information below:

Insurance Name: _____ Plan Name: _____

Subscriber ID: _____ Effective Date: _____

Group ID: _____

Primary Insurance Holder Name (Policy Holder): _____

Policy Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____

If **UNINSURED**, please initial below to attest that the following information is true and accurate:

_____ *I do not have any insurance, including but not limited to Medicare, Medicaid, or any other private or government-funded health benefit plan.*

In order to have your vaccine administration fee paid for by the United Stated Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, **please provide either (a) a valid Social Security number (ABOVE), (b) State Identification Number and State of issuance, OR (c) a driver's license number and the State of issuance.**

_____ _____ _____

Driver's License Number & State OR State ID Number & State

COVID-19 VACCINE SCREENING & CONSENT FORM

Patient Name: _____ **Date of Birth:** _____

- I certify that I am: (a) the patient and at least 18 years of age; or (b) legally authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Metro Inclusive Health to administer the COVID-19 vaccine.
- I understand that if receiving Moderna or Pfizer (for ages 12-17 only) that those products have not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 12 years of age or older; 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 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 (or more in specific cases) 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 Metro Inclusive Health, the State of Florida, the Florida Department of Health (DOH), the Florida Division of Emergency Management (FDEM) 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 Florida SHOTS, Florida's immunization registry and (b) Metro Inclusive Health will include my personal immunization information in Florida SHOTS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize Metro Inclusive Health 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 Metro Inclusive Health with respect to the above requested items and services. I understand that I will not be charged a fee for the vaccine or its administration.

Signature of Patient: _____ **Date**: _____

Pfizer only: If 12 years old – 17 years old

- I certify that I am: the legal guardian of the patient and confirm that the patient is at least 12 years of age; or (b) legally authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Metro Inclusive Health to administer the COVID-19 vaccine.

Signature of Parent/Guardian/Authorized Representative: _____ **Date**: _____

Print Name of Parent/Guardian/Authorized Representative: _____

_____ **FOR CLINIC USE ONLY** _____

Clinic site (Circle One): STP TPA NPR CLW Mobile-Unit Inclusivitea **EUA Fact Sheet Provided**: Yes No

Date vaccine administered: ____/____/_____ **Date booster required**: ____/_____/_____

Vaccine manufacturer (Circle One): Pfizer Moderna

Lot number: _____ **Expiration Date:** _____

Site of IM injection: RDT or LDT

Print name and Title of Vaccine Administrator: _____

Signature of Vaccine Administrator: _____ **Date:** _____