☐AGE ☐FF ☐HC ☐LEO ☐MV ☐K12

COVID-19 VACCINE SCREENING & CONSENT FORM

PFIZER COVID-19 VACCINE

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

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

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

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

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

ESTABLISHED METRO PATIENTS ONLY:

Do you have insurance? ☐ No ☐ Yes

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, you must 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, (b) State Identification Number and State of issuance, OR (c) a driver's license number and the State of issuance.**

_____ _____ _____

Social Security Number or State ID Number & State or Driver's License Number & State

Is this the patient's first or second dose of the COVID-19 Vaccination: ☐ First Dose ☐ Second Dose

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 other vaccinations in the last 14 days?		
5. Have you had any COVID-19 Antibody therapy within the last 90 days (i.e. Regenron, Bamlanivimab, COVID Convalescent Plasma, etc.)?		

IMMUNIZATION SCREENING QUESTIONS

Please check YES or NO for each question.	Yes	No
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. For women, are you pregnant or is there a chance you could become pregnant?		
3. For women, are you currently breastfeeding?		
4. Are you immunocompromised or on a medication that affects your immune system?		
5. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
6. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive?		

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COVID-19 VACCINE SCREENING & CONSENT FORM

PFIZER COVID-19 VACCINE

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

- I certify that I am: (a) the patient and at least 16 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 16 years of age; or (c) 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 this product has 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 either 16 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 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 (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 or Authorized Representative: _____ **Date**: _____

Print Name of Representative and Relationship to Person Receiving the Vaccine: _____

_____**FOR CLINIC USE ONLY**_____

Clinic site: _Metro Inclusive Health – St. Petersburg__ **Site Address:** 3251 3rd Ave. N., St. Petersburg, FL 33713

EUA Fact Sheet Provided: Yes No

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

Vaccine manufacturer: _Pfizer_____ **Lot number**: _____

Expiration Date: _____

Site of IM injection: RDT or LDT

Print name and Title of Vaccine Administrator: _____

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