VACCINE SCREENING & CONSENT FORM

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

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

Phone: _(_____)_____ **SSN #:** _____-_____-_____

Sex Assigned At Birth: ☐ *Male* ☐ *Female* **Gender Identity:** _____ **Pronouns:** _____

Race: ☐ *Asian* ☐ *Black* ☐ *Native American* ☐ *Pacific Islander* ☐ *White* ☐ *Other*

Ethnicity: ☐ *Hispanic* ☐ *Haitian* ☐ *Non-Hispanic/Non-Haitian*

☐ *COVID-19 Comirnaty (Pfizer) 2023-24 Monovalent Vaccine*	☐ *Flu Vaccine (Flucelvax Quadrivalent)* ☐ *High Dose Flu Vaccine (ONLY for 65yrs of age and older)*

Please indicate below which Vaccine dose(s) you would like today:

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 30 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?*		

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 <u>INSURED</u>, *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:* _____

If <u>UNINSURED</u>, 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.*

Consent for Vaccination (continued on back):

- *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 vaccine(s).*
- *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 provided for the vaccine(s) 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 of the COVID vaccine for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.*

VACCINE SCREENING & CONSENT FORM

- *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.*

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

Print Name: _____ *Birth date:* _____/_____/_____

FOR METRO HEALTH CENTER STAFF USE ONLY

Health Center Location *(circle one): STP NSTP CEN TPA BRN NPR CLW*

Mobile-Unit: _____
(indicate community location)

Fact Sheets Provided *(circle as applicable):* **FLU**: *Yes No* **COVID-19 COMIRNATY**: *Yes No*

Flu Vaccine

Date vaccine administered: ____/____/_____

Vaccine manufacturer: *Seqirus*

Lot number: _____

Expiration Date: _____

Site of IM injection: *RDT or LDT*

COVID-19 Vaccine

Date vaccine administered: ____/____/_____

Vaccine manufacturer: *Pfizer*

Lot number: _____

Expiration Date: _____

Site of IM injection: *RDT or LDT*

Print Name of Vaccine Administrator: _____ *(circle one) MA LPN RN PA*

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