Arnett Hospital

COVID-19 VACCINATION

Patient Sticker

Screening Questionnaire/Patient Consent/Vaccine Administration Record

Information About Person to Receive Vaccine *(Please Print)*			
Name (Last, First, Middle Initial)		**Date of Birth**	**Age**
Street Address	**City**	**County**	**State**
Gender *(circle one)* **M F Other**	**Mother's Maiden Name** *(if patient is 0-18 years old)*	**Guardian** *(if patient is 0-18 years old)*	

Patient/Parent/Legal Guardian: Please complete the questions below to help us determine if there is any reason we should not give you or your child a COVID-19 vaccine today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.	Yes	No	Don't Know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product			
3. Have you ever had an allergic reaction to: (this would include severe allergic 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.)			
• A component of a COVID-19 vaccine including either of the following:			
o Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
o Polysorbate, 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 it is not known which component elicited the immediate reaction.	☐	☐	☐
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen8 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.)	☐	☐	☐
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.	☐	☐	☐
6. Have you received any vaccine in the last 14 days?	☐	☐	☐
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
10. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
11. Are you pregnant or breastfeeding?	☐	☐	☐
12. Do you have dermal fillers?	☐	☐	☐

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COVID-19 VACCINATION

PATIENT CONSENT FOR COVID-19 VACCINATION:

Patient Sticker

Explanation of Vaccination:
Vaccination for COVID-19 is an intramuscular injection. Intramuscular injections are administered at a 90 degree angle to the skin, preferably into the deltoid muscle of the upper arm. Risks associated with this vaccination include mild side effects, such as fever, injection site pain, headache, nausea, muscle aches and fatigue, and a small percentage may still be vulnerable even after receiving the vaccine. There is a remote chance the COVID-19 vaccine could cause a severe allergic reaction or other side effects such as blood clots (see CDC Vaccination Information Sheet for additional benefits and risks). The Pfizer vaccine and Moderna vaccine will require two (2) doses to work, and you will need to return for the second dose within the recommended time frame. The Janssen (Johnson & Johnson) vaccine requires only one (1) dose. The COVID-19 vaccine is presently available under an Emergency Use Authorization (EUA) issued by the U.S. Food and Drug Administration (FDA).

Patient's Consent:

- I certify that I am at least eighteen (18) years of age and am consenting to my own health care or that I am an authorized representative of the patient and can consent on behalf of the patient.
- I confirm that I have received and read a copy of the CDC Vaccination Information Statement for the COVID-19 vaccine to be given today [i.e. Pfizer, Moderna or Janssen (Johnson & Johnson)].
- I confirm that I have been informed about the vaccine purpose, procedure, and risks, and I have elected to receive.
- I understand this vaccination may be subject to reporting to a health information exchange or an immunization registry, who may share my vaccine information with others, and to my health care providers, for treatment purposes or as otherwise permitted by law.
- I have been told to remain in the vaccine treatment area for 15 minutes after receiving the vaccine to watch for any reactions to the vaccine. I have also been told not to drive for 15 minutes to make sure I have not had a reaction.
- I have also had the opportunity to have all my questions addressed before receiving the COVID-19 vaccine.
- I voluntarily consent and agree to receive the vaccination for COVID-19.

Form Completed By: _____ _____ _____
Printed Name *Date* *Time*

_____ _____
Signature *Relationship to Patient*

Section Below For Office Use Only

Form Reviewed By: _____ _____ _____
Clinical team member printed name AND Cerner Username *Signature* *Date*

☐ **Vaccine given by protocol**

VACCINE ADMINISTRATION RECORD Vaccine administration must also be documented in the Vaccine Record in the EMR

Clinic/Office/Treatment Location and Address:

Manufacturer:	Lot Number:	Expiration Date:
☐ Single-dose Janssen (Johnson & Johnson) ☐ Pfizer (CHECK: ____ 1st Dose or ____ 2nd Dose) ☐ Moderna (CHECK: ____ 1st Dose or _____ 2nd Dose)	Dosage: ____ mLs	_____/_____/_____
		Date and Time of Administr a tion: _____/_____/_____ ____:____ ☐Am ☐Pm

Date VIS given to Patient:	VIS Published Date:	Administration Route:	Administration Date:
_____/_____/_____	_____/_____/_____		

Vaccine Administrator Signature/Title	*Date*

22

COVID-19 VACCINATION
(Page 2 of 2)

Other Consent

Y-4