COVID Vaccine Intake Consent Form

Patient Information

☐ M ☐ F

Last Name | First Name | Date of Birth | Gender

Address:_____
Street | Apt. # | City | Zip

Phone # (____)_____ (____)_____ (____)_____
Home | Work | Cellular

Race:
☐ American Indian / Alaska Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian / Pacific Islander ☐ White ☐ Other Race

Ethnicity:
☐ Hispanic / Latino ☐ Non-Hispanic / Latino

Insurance Information

*Patient Disclosure: The vaccine is being provided at no cost by the government. Your insurance information will be charged for the cost of administering your vaccination. You are not personally responsible for any costs.

Insurance Type | Insurance Company Name | Member ID Number | Group Number

Policy Holder Last Name | Policy Holder First Name | Policy Holder Date of Birth

Policy Holder Relation to Patient

Vaccine Administration Information (internal use only)

Administration Date | Vaccine Type | VIS Date | Manufacturer | Volume (mL)

☐ L ☐ R

LOT # | Expiration Date | Route | Site

Administering Immunizer Name and Title | Administering Immunizer Signature

V2 – 01/08/2021
Bay Area Community Health – Covid-19 Vaccination Healthcare Worker and Patient Consent Form
Sources: DHHS CDC, Greg Facktor & Associates, LLC

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Patient Name:_____

COVID Vaccination Screening Questions	YES	NO	DON'T KNOW
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19?	☐	☐	☐
If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ other: _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) in the past? Example: a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?	☐	☐	☐
– Was there severe allergic reaction after receiving a COVID-19 vaccine?	☐	☐	☐
– Was there severe allergic reaction after receiving another vaccine or injectable medication?	☐	☐	☐
4. Have you received any vaccines in the past 14 days?	☐	☐	☐
5. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days?	☐	☐	☐
6. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
7. Do you have a weakened immune system or currently take medications that can diminish your immune response? (i.e., HIV medications, steroids, anticancer drugs or radiation treatment, etc.)	☐	☐	☐
8. For women, are you currently breastfeeding or pregnant?	☐	☐	☐

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CONSENT FOR VACCINATION

I have been provided with the Moderna COVID-19 Vaccine Fact Sheet for Recipients and Caregivers. I have read the information provided about the vaccine I am about to receive and have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccination. I understand that I should remain in the vaccine administration area for a minimum of 15 minutes after the shot to be monitored for any potential adverse events.

DISCLOSURE OF RECORDS

I understand that BACH may be required to disclose my health information to state or federal registries for purposes of treatment or other needs such as public health purposes, surveillance tracking and safety monitoring. The following individually identifiable health information may be disclosed: vaccination type and identification numbers, date of vaccination, including all doses and subsequent follow-up information. I hereby consent to BACH staff to access my electronic medical record for the purpose of documenting my vaccination encounters.

X _____

Signature of patient to receive vaccine (or parent, guardian or authorized representative) Date

If signing on behalf of the patient, you are stating that you are authorized to provide the required consents on behalf of the patient.

_____

Name of patient to receive vaccine

_____

Name of parent, guardian, or authorized representative Phone Number Relationship