



COVID-19 VACCINE SCREENING AND CONSENT FORM

Administration Facility Name/FacilityID: FDOH Bay County Health Department

SECTION 1: INFORMATION ABOUT PATIENT (PLEASE PRINT)

Name: Last: _____ First: _____ Middle Initial: _____				
Date of Birth: Month _____ Day _____ Year _____	Mobile Phone Number (Patient or Guardian): () _____			
Address: _____ Apt/Room #: _____				
City: _____ State: _____ Zip: _____				
Name of Legal Guardian: Last: _____ First: _____ Middle Initial: _____				
Sex (Gender assigned at birth) <input type="checkbox"/> Female <input type="checkbox"/> Male	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American</td> <td style="width: 33%;"><input type="checkbox"/> Native Hawaiian or other <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White</td> <td style="width: 33%;"><input type="checkbox"/> Other Asian <input type="checkbox"/> Other Nonwhite <input type="checkbox"/> Other Pacific Islander</td> </tr> </table>	Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or other <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> Other Asian <input type="checkbox"/> Other Nonwhite <input type="checkbox"/> Other Pacific Islander
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Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown				
Primary Insurance Carrier ID #: _____ Grp #: _____ Insurance Company : _____ Insurance Company Phone # _____ Insured's Name: _____ Relationship: _____ Insured's Date of Birth _____				
Secondary Insurance Carrier ID #: _____ Grp #: _____ Insurance Company : _____ Insurance Company Phone # _____ Insured's Name: _____ Relationship: _____ Insured's Date of Birth _____				
Designation of COVID-19 vaccination dose number? <input type="checkbox"/> First Dose <input type="checkbox"/> Second Dose <input type="checkbox"/> Third Dose*				

SECTION 2: COVID-19 SCREENING QUESTIONS

Please check YES or No for each question.	Yes	No
1. Do you have today or have you had at any time 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, nausea, vomiting, or diarrhea?		
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 (e.g. 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 (e.g. Regeneron, COVID Convalescent Plasma, etc.)		

SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE

Please check YES or No for each question.	Yes	No
5. Do you carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, foods, vaccines or latex?		
6. For women, are you pregnant or is there a chance you could become pregnant?		
7. For women, are you currently breastfeeding?		
8. Are you immunocompromised or on a medication that affects your immune system?		
9. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
10. Are you a female age 18 to 49 years old receiving the Janssen (Johnson and Johnson) COVID-19 vaccine?		
11. If you are under the age of 18 are you and/or your guardian aware that you are only eligible to receive the Pfizer vaccine?		
12. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive:		
*13. If this is your <u>third dose</u> , are you moderately to severely immunocompromised (e.g. solid organ transplant recipient, immunosuppressant medications, active treatment for cancer, etc.) Note that a third dose of mRNA vaccine is only recommended at this time for those who are moderately to severely immunocompromised and must occur at least 28 days after the previous mRNA vaccine dose.		

- I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 12 years of age (for Pfizer vaccine consent only); or (c) legally authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Florida Department of Health (DOH) or its agents to administer the COVID-19 vaccine.
- Currently, Pfizer is the only COVID-19 vaccine product that has been fully approved and licensed by FDA. This FDA approval and license is for use in individuals 16 years of age and older only. I understand that this product (other than Pfizer for usage in ages mentioned above only) 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 12-15 years of age (Pfizer only) or 18 years of age and older (Moderna and Johnson and Johnson); 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 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) DOH 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 DOH, FDEM, or its agents 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 DOH, FDEM, or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if DOH invoices me after the time of service, upon receipt of such invoice.
- I acknowledge receipt of the DOH Notice of Privacy Practices.

Signature of Patient or Authorized Representative _____ **Date:** _____

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

Site (LD/RD)	Route	Manufacturer (MVX)	Lot # Unit of Use/ Unit of Sale	Expiration Date	Date of EUA Fact Sheet
	IM				

Administered at location: facility name/ID	Florida Department of Health in Bay County
Administered at location: Type	FDOH Bay County Health Department
Administration Address:	597 West 11th Street Panama City, FL 32401 (850)872-4455
CVX (product)	
Sending organization:	

Vaccinator Print Name: _____ **Signature:** _____ **Date:** _____

Vaccine administering providersuffix: _____