COVID Vaccine — Informed Consent for Vaccination

COVIDCONSENT

Please **complete Sections A, B, C** for all immunizations **prior** to clinic date.
Medical/Pharmacy insurance (Section D), must be **completed** if the **person** receiving the vaccine is not currently receiving any pharmacy services from LI Script.

SECTION A

First name: _____ **Last name:** _____

Date of birth: _____ **Age:** _____ **Phone:** _____

Home address: _____ **City:** _____

State: _____ **ZIP code:** _____ **Mother's Maiden Name** (mandatory for NYC locations): _____

Sex	Race			Ethnicity
☐ Female	☐ American Indian or Alaska Native	☐ Native Hawaiian or other	☐ Other Asian	☐ Hispanic or Latino
☐ Male	☐ Asian	☐ Pacific Islander	☐ Other Nonwhite	☐ Not Hispanic or Latino
☐ Unknown/Undifferentiated	☐ Black or African American	☐ White	☐ Other Pacific Islander	☐ Unknown
	☐ Unknown	☐ Unable to report due to policy/law		☐ Unable to report due to policy/law

If you are part of a Senior Facility clinic, are you a ◯ resident or an ◯ employee/staff?
Is this the patient's ◯ first or ◯ second dose of the COVID-19 vaccination?

SECTION B

The following questions will help us determine your eligibility to be vaccinated today.

COVID-19 Screening Questions	Yes	No	Don't Know
1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?	◯	◯	◯
2. In the past two weeks, have you had contact with anyone who tested positive for COVID-19?	◯	◯	◯
3. Have you had the new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?	◯	◯	◯
4. Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? If yes, when did you receive the last dose?	◯	◯	◯
5. Have you had any vaccines in the past 14 days (2 weeks) including flu shot? If yes, how long ago was your most recent vaccine? Date if applicable:	◯	◯	◯

To be filled out by the immunizer: Patient Temperature: Date:

If the patient answers yes to any of these questions or bodily temperature is 100°F or greater, please inform them that they should not receive the vaccine at this time, instruct them to contact their primary care provider for next steps and that the facility coordinator will be notified.

Immunization Screening Questions	Yes	No	Don't Know
1. Are you sick today? (For example: a cold, fever or acute illness)	◯	◯	◯
2. Do you have allergies to latex, medications, foods or vaccines? (For example: eggs, gelatin, neomycin, phenol, thimerosal, etc.)	◯	◯	◯
3. Have you ever had a serious reaction after receiving a vaccination? Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	◯	◯	◯
4. Do you take anticoagulation medication? For example: Warfarin, Coumadin or other blood thinner.	◯	◯	◯
5. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?	◯	◯	◯
6. Do you have a weakened immune system or in past 3 months, taken medications that weaken it such as cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments?	◯	◯	◯
7. Have you received a previous dose of COVID-19 vaccine? Date if applicable:	◯	◯	◯
8. For women: Are you pregnant or considering becoming pregnant in the next month?	◯	◯	◯
9. Have you received any vaccinations or TB skin test in the past 4 weeks?	◯	◯	◯

SECTION C

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to LI Script and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the vaccine(s) I have requested above. 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(s) and have received, read and/or had explained to me the Vaccine Information Statements on 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. Further, I acknowledge that I have been advised to remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its 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(s) listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the applicable Provider: (a) the disclosure of my vaccination information by the applicable Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and, to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my vaccination information to or through the State HIE as required or permitted by law. I also authorize the applicable Provider to disclose my, or my child's (or unemancipated minor for whom I am authorized to act as guardian or in loco parentis), proof of vaccination to the school where I am, or my child (or unemancipated minor for whom I am authorized to act as guardian or in loco parentis) is, a student or prospective student. I further authorize the applicable Provider to: (a) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to, or through, the State HIE to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice.

Patient signature: _____ Date: _____

SECTION D **INSURANCE – PATIENT TO COMPLETE IF APPLICABLE**

Please ensure to record BOTH pharmacy AND medical insurance information since there are multiple ways immunizations can be billed

	Pharmacy Card	Medical Card
Insurance Plan/Plan ID:		
Member/Recipient ID Number:		
RX BIN:		N/A
RX PCN:		N/A
Group Number:		

Are you the cardholder? ◯ Yes ◯ No

If no, please provide cardholders name, date of birth (MM/DD/YYYY) and relationship: _____

_____

SECTION E **HEALTHCARE PROVIDER ONLY**

Complete **BEFORE** vaccine administration

1. I have reviewed the Patient Information and Screening Questions. Initial here: _____
2. I have verified that this is the vaccine requested by the patient. Initial here: _____
3. The vaccine is appropriate for this patient based on the Age Guidelines provided by federal and/or state regulations and company policies. Initial here: _____

   3a. Does this patient have a high-risk medical condition? ◯Yes ◯No
   If yes, please list medical condition(s): _____
4. The Vaccine NDC matches the NDC on the bottom of this VAR form and the NDC on the patient leaflet. (Perform 3-way NDC match.) Initial here: _____
5. I have verified the Expiration Date is greater than today's date and have entered the Lot# and Expiration Date in the field below. Initial here: _____
6. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder? Initial here: _____

For Vaccine

Lot #: _____ Expiration Date: _____

SECTION F

Complete **DURING** the patient interaction

1. I have asked the patient to confirm their Name, DOB and Requested Vaccine and verified it matches the information on the VAR form. Initial here: _____
2. I have reviewed the Screening Questions with the patient. Initial here: _____
3. I have reviewed the EUA with the patient. Initial here: _____

SECTION G

Complete **AFTER** vaccine administration

Vaccine	Manufacturer	Dosage	Site of Administration	EUA published date

Immunizer's name (print): _____ Immunizer's signature: _____ Title: _____

If applicable, intern name (print): _____ Administration date: _____ Date VIS given to patient: _____

Driver's License #/Government ID (if applicable): _____

NOTES

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