COVID-19 Immunization Screening and Consent Form

Demographic Information			
Recipient Name (please print) **First:** **MI:** **Last Name:**			
DOB:	**Gender:**	**Marital Status:**	
Street address:	**City:**	**State:**	**Zip**
Parent/Guardian/ Surrogate (if applicable, please print)	**Phone:**	**Email Address:**	
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown or decline		**Race** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other pacific islander ☐ White ☐ Other race ☐ Unknown or declined	
Clinic/Office Site Where Vaccine is Administered:	**Primary Care Physician Address/Phone Number:**		

Shekinah
HEALTH & WELLNESS CENTER

Insurance Information

☐ **Please check this box if Uninsured**

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_____

Screening Questionnaire

1.	Are you feeling sick today?	☐ Yes	☐ No	
2.	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?	☐ Yes	☐ No	
3.	In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	☐ Yes	☐ No	☐ Unknown
4.	Have you been treated with antibody therapy for COVID-19 in the past 90 days (3 months)? *If yes, when did you receive the last dose?*	☐ Yes	☐ No	☐ Unknown
5.	Have you ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing, to any vaccine or shot?	☐ Yes	☐ No	☐ Unknown
6.	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?*	☐ Yes	☐ No	☐ Unknown
7.	Are you pregnant, breastfeeding or planning to become pregnant?	☐ Yes	☐ No	☐ Unknown
8.	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	☐ Yes	☐ No	☐ Unknown
9.	Do you take any medications that affect your immune system, such as cortisone, prednisone or, other steroids, anticancer drugs or have you had any radiation treatments?	☐ Yes	☐ No	☐ Unknown

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA issued when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Consent

☐ I certify that I am: (a) the patient and at least 16 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 16 years of age; or (c) legally authorized to consent for vaccination for the patient named above.

☐ I hereby give my consent to Shekinah Health and Wellness Center or its employees to administer the COVID-19 vaccine. I understand the risks and benefits associated with the above vaccine.

☐ I understand that if the available vaccine requires two doses, I will need to follow up for the second dose for it to be most effective. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s).

☐ I have been provided and have read, or had explained to me, the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. All FDA Approved Fact Sheets are available on SHWC COVID-19 Page info at www.shekinahealth.com. I also acknowledge that I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions).

☐ I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, Shekinah Health & Wellness Center, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries. I further authorize SHWC 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 SHWC with respect to the above requested items and services.

☐ I understand that this product 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 16 years of age or older or 18 years of age and older; 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 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. Any other unexpected reaction needs to be reported to your healthcare provider.

☐ On behalf of myself, my heirs, and personal representatives, I hereby release and hold harmless Shekinah Health & Wellness Center 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) SHWC will include my personal immunization information in Florida SHOTS and my personal immunization information will be shared with Florida Department of Health and/or Centers for Disease Control (CDC) or other federal agencies.

☐ I acknowledge receipt of the SHWC Notice of Privacy Practices.

NOTE: Depending on the vaccine type, a second of dose of COVID-19 vaccine may be due on 21 or 28 days after the initial vaccine. Please refer to your COVID-19 Vaccination Record Card for second dose due date. Keep your COVID-19 vaccination record card for your records and proof of vaccination dates.

Signature

My signature below indicates I have read, understand, and agree to the sections above, Release and Assignment of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).

Signature of patient or guardian: _____ Date: _____