IRMC

COVID-19 Immunization Screening and Consent Form

Recipient Name (*Please Print*) ____
First **Middle** **Last**

Date of Birth __________________________________ **Legal Gender**: Male Female

Race: _________________________ **Ethnicity**: Non-Hispanic Hispanic Unknown Declined

Address: ____ **County**: ___________________

City:___________________________ **State**:____________________ **Zip Code**: _________________________

Primary Phone Number: ______________________________ **Employer**: ______________________________

Screening Questionnaire

Are you feeling sick today?	Yes	No	
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 a COVID-19 infection or exposure?	Yes	No	Unknown
Have you been treated with antibody therapy for COVID-19 in the past 90 days? If yes, when was the last dose?	Yes	No	Unknown
Have you ever had a life-threatening allergic reaction, such as hives or difficulty breathing to any vaccine or shot?	Yes	No	Unknown
Have you had any vaccines in the past 14 days (2 weeks) including a flu shot?	Yes	No	Unknown
Are you pregnant or considering becoming pregnant?	Yes	No	Unknown
Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	Yes	No	Unknown
Do you take any medications that affect your immune system such as cortisone, prednisone or other steroids, anticancer drugs or have you had any recent 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 is used 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 decisionto 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 have been provided and have read, or been explained to me, the information sheet regarding the COVID-19 vaccination. I understand that if this vaccine requires two doses, the two doses will need to be administered (given) in order for it to be effective. I have been given the opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me. I understand there will be no cost to me for this vaccine. I authorize release of all information needed for public health purposes including reporting to applicable vaccine registries.

Recipient Signature: ____

Printed Name: ____

Date: ____________________________________ Time: ________________

Vaccinator: Complete Back of Form