

COVID-19 Vaccination Consent under Emergency Use Authorization

PATIENT DEMOGRAPHIC INFORMATION

*Last Name:		*First Name:		Middle Initial:
*Date of Birth / /		*Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Transgendered <input type="checkbox"/> Other <input type="checkbox"/>		
*Race White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/>		Hispanic Ethnicity: Yes <input type="checkbox"/> No <input type="checkbox"/>		
American Indian/Alaskan Native <input type="checkbox"/> None Specified <input type="checkbox"/> Refused <input type="checkbox"/>		Unknown <input type="checkbox"/> Refused <input type="checkbox"/>		
Address:				City:
State:	Zip:	Home Phone:		Cell Phone:
Email:		Would like a reminder for the next appointment Yes <input type="checkbox"/> or No <input type="checkbox"/> postcard/call/text		
Private or employer insurance <input type="checkbox"/>		Underinsured <input type="checkbox"/>	Uninsured <input type="checkbox"/>	Medicaid <input type="checkbox"/>

HEALTH HISTORY

	<u>YES</u>	<u>NO</u>	<u>UNKOWN</u>
1. Are You moderately or severely ill today? <i>(mild illnesses or taking antibiotics are not reasons to withholding vaccination)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do You have any allergies to foods or medications? If yes, please list	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. In the past 14 days have you Tested Positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had Contact with another person with lab confirmed COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. In the past year, have you been diagnosed with COVID-19 by a medical provider? If yes, date of diagnosis: _____/_____/_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you breastfeeding, pregnant or planning on becoming pregnant in the next six months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. In the past 3 months, have you taken medications that affect your immune system? <i>Such as prednisone, other steroids, anticancer drugs, drugs for treatment of rheumatoid arthritis, Crohn's disease or psoriasis; or have you had radiation treatments</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you currently have or a history of neurological condition, seizure or have ever had Guillain Barré Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past year, have you received a dose of COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICP to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The CICP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use of covered countermeasures identified in a PREP Act declaration. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV-2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any such product. Information about the CICP and filing a claim is available by calling 1-855-266-2427 or visiting <http://www.hrsa.gov/cicp/>.

PLEASE PRINT NAME of signature below

SIGNATURE OF PATIENT

RELATIONSHIP TO CLIENT

TODAY'S DATE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge and agree that I have received or have been advised of the Missouri Department of Health and Senior Services' Notice of Privacy Practices and where I can obtain any revisions made to this Notice.
Print NAME HERE

Client Signature/Legal Representative

Relationship to Client

Today's Date

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For Clinic Use only

Manufacturer	Brand	Lot number
Dose number 1 <input type="checkbox"/> or 2 <input type="checkbox"/>	*Exp. Date: ___/___/___	*Date Administered: ___/___/___
*EUA fact sheet date: ___/___/___	* EUA fact sheet given date: ___/___/___	Injection Site (Deltoid) L <input type="checkbox"/> R <input type="checkbox"/>
*Administered by Name & Title :		
*Agency:		
*Agency Address		
*Clinic administration address		