COVID-19 Vaccine Consent & Questionnaire - Universal

Date	Recipient temperature	Recipient weight

Patient Information

Name (please print)			Parent/Guardian (if applicable please print)
DOB	Age	Gender	Preferred Language
Address		City State Zip	
Phone Number			Email Address

Ethnicity (circle one)

Hispanic Not Hispanic or Latino Unknown Declined

Race (circle one)

American Indian or Alaska Native Asian Native Hawaiian/Other Pacific Islander

Black or African American White Other Race Declined

Screening Questions (circle one)

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Are you feeling sick today?	Yes	No	
2. Have you ever received a dose of COVID-19 vaccine?	Yes	No	Unknown

- If yes, which vaccine product did you receive?

☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another Product: _____

3. Have you ever had an allergic reaction to:
(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)

- A component of the COVID-19 vaccine including either of the following:

• Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	Yes	No	Unknown
• Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.	Yes	No	Unknown
• A previous dose of COVID-19 vaccine	Yes	No	Unknown

4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)	Yes	No	Unknown
5. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised?	Yes	No	Unknown

If yes, check all that apply to you:

- ☐ Been receiving active cancer or HIV treatment
- ☐ Received an organ transplant and are taking medicine to suppress the immune system
- ☐ Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system
- ☐ Moderate to severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
- ☐ Advanced or untreated HIV infection
- ☐ Active treatment with high-dose corticosteroids or other drugs (methotrexate, azathioprine, leflunomide, adalimumab, rituximab, tacrolimus, cyclosporine, mycophenolate) that may suppress your immune response

6. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	Yes	No	Unknown

Additional CDC Screening Questions

Check all that apply to you:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a history of Guillain-Barré syndrome (GBS)
- ☐ Have a history of COVID-19 disease within the past 3 months.

Primary Series Vaccine Information

Please complete this section if you have already received a previous COVID-19 vaccine dose(s).

Primary series vaccine for Pfizer (ages 5+) and Moderna (ages 18+) is considered 2 (two) doses and for Janssen (ages 18+) is considered 1 (one) dose. Primary series vaccine for Pfizer (6 months – 4) is considered 3 (three) doses and Moderna (6 months – 5) is considered 2 (two) doses.

Please see additional information regarding immunocompromised individuals on the following page.

Date of 1st dose	____ / ____ / _____ ☐ Unknown	Vaccine administered: ☐ Pfizer ☐ Moderna ☐ Janssen ☐ Another product: _____
Date of 2nd dose	____ / ____ / _____ ☐ Unknown	Vaccine administered: ☐ Pfizer ☐ Moderna ☐ Another product: _____
Date of 3rd dose	____ / ____ / _____ ☐ Unknown	Vaccine administered: ☐ Pfizer ☐ Another product: _____

Immunocompromised Additional Primary Series Information

If you are considered immunocompromised, you should receive an additional primary series dose of the Pfizer (ages 5+) or Moderna (ages 18+) COVID-19 vaccine 28 days after your primary series.

Date of additional dose	____ / ____ / _____ ☐ Unknown	Vaccine administered: ☐ Pfizer ☐ Moderna ☐ Another product: _____

COVID-19 Vaccine Bivalent Booster Shot Information Pfizer, Moderna, & Janssen*

If you received primary series: Pfizer-BioNTech (Comirnaty)	**Age Group:** Ages 5+	**When to get a booster:** At least 2 months after completing your primary COVID vaccination series *For immunocompromised, at least 2 months after additional primary series dose*	**Which booster can you get:** Ages 5-11 can get a Pfizer Bivalent booster Ages 6-11 can get a Pfizer Bivalent or Moderna Bivalent booster **Which booster can you get:** Ages 12+ can get a Pfizer Bivalent or Moderna Bivalent booster
If you received primary series: Moderna (Spikevax)	**Age Group:** Ages 5+	**When to get a booster:** At least 2 months after completing your primary COVID vaccination series *For immunocompromised, at least 2 months after additional primary series dose*	**Which booster can you get:** Ages 5-11 can get a Pfizer Bivalent booster Ages 6-11 can get a Pfizer Bivalent or Moderna Bivalent booster **Which booster can you get:** Ages 12+ can get a Pfizer Bivalent or Moderna Bivalent booster
If you received primary series: Janssen (Johnson & Johnson)	**Age Group:** Ages 18+	**When to get a booster:** At least 2 months after completing your primary COVID vaccination *For immunocompromised, at least 2 months after additional primary series dose*	**Which booster can you get:** Ages 18+ can get Pfizer Bivalent or Moderna Bivalent booster

*The CDC recommends individuals receive an mRNA (Pfizer or Moderna) COVID-19 vaccine over Johnson & Johnson's (Janssen) COVID-19 vaccine.

By signing this form, I attest that it has been the recommended amount of time, as stated by the CDC, since completion of my COVID-19 primary series vaccine, including additional doses for immunocompromised people.

Sign Here: _____ Date: _____

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 a 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 for Services

I have been provided with information to access the EUA and/or Fact Sheet for the corresponding COVID-19 vaccine(s) that I am receiving. I understand that the Pfizer and Moderna vaccine require two (2) or three (3) doses dependent on age and immunocompromised people, and the Janssen vaccine requires one (1) dose (two (2) doses for immunocompromised people) to be administered in order for it to be effective. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction, I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the post vaccine waiting area for at least 15 minutes (30 minutes if necessary) after the vaccination to be monitored for any potential adverse reactions. I understand that if I experience side effects that I should do the following: contact the VNA Health Care or call 911. I request that the vaccine be given to me or to the person for whom I am authorized to make this request.

Disclosure of Records

I understand that VNA Health Care may be required to or may voluntarily disclose all my health information needed to report administration of vaccine and/or other public health purposes, including reporting to applicable vaccine registries.

Consent for Communication

By signing below, I agree to receive future communications from VNA Health Care via email, phone call or text message. If you wish not to receive emails, phone calls or text messages from VNA Health Care.

Please initial here to opt out. _____

_____

Recipient/Guardian Signature

_____

Print Name

_____

Relationship to patient, other than recipient

_____ _____

Date Time

Vaccine Administration
Office Use Only

Vaccine Location (CIRCLE ONE)

VNA-Highland VNA-Indian VNA-Villa VNA-Wing VNA-Mona Kea VNA-Mobile Clinic

VNA-Bensenville VNA-Bolingbrook VNA-Romeoville VNA-Joliet VNA-Offsite Clinic

Primary Series (CIRCLE DOSE)

	Pfizer-BioNTech		Pfizer-BioNTech (Comirnaty)	Moderna	Moderna	Moderna (Spikevax)	Janssen (Johnson & Johnson)
Age Range	**6 months -4**	**5-11**	**12+**	**6 months -5**	**6-11**	**12+**	**18+**
First Dose	0.2 mL	0.2 mL	0.3 mL	0.25 mL	0.5 mL	0.5 mL	0.5 mL
Second Dose	0.2 mL	0.2 mL	0.3 mL	0.25 mL	0.5 mL	0.5 mL	N/A
Third Dose	0.2 mL	N/A	N/A	N/A	N/A	N/A	N/A
Third Dose Immunocompromised	N/A	0.2 mL	0.3 mL	N/A	0.5 mL	0.5 mL	N/A

Booster Vaccine (CIRCLE DOSE)

	Pfizer-BioNTech Bivalent		Pfizer-BioNTech (Comirnaty) Bivalent		Moderna (Spikevax) Bivalent			Janssen (Johnson & Johnson)	
	Ages 5-11		**Ages 12+**		**Ages 6-11**	**Ages 12+**		**Ages 18+**	
Primary Series	**Dose**	**Interval**	**Dose**	**Interval**	**Dose**	**Dose**	**Interval**	**Dose**	**Interval**
Pfizer	0.2 mL	2 months	0.3 mL	2 months	0.25 mL	0.5 mL	2 months	0.5 mL	5 months
Pfizer Immunocompromised	0.2 mL	2 months	0.3 mL	2 months	0.25 mL	0.5 mL	2 months	0.5 mL	3 months
Moderna	0.2 mL	2 months	0.3 mL	2 months	0.25 mL	0.5 mL	2 months	0.5 mL	5 months
Moderna Immunocompromised	0.2 mL	2 months	0.3 mL	2 months	0.25 mL	0.5 mL	2 months	0.5 mL	3 months
Janssen	N/A	N/A	0.3 mL	2 months	0.25 mL	0.5 mL	2 months	0.5 mL	2 months
Janssen Immunocompromised	N/A	N/A	0.3 mL	2 months	0.25 mL	0.5 mL	2 months	0.5 mL	2 months

Administration Site (circle one) Left Deltoid Right Deltoid Left Thigh Right Thigh

Manufacturer Lot Number: **Expiration Date:**

Vaccine Administrator Signature