ADELANTE HEALTH CENTER

Recipient COVID-19 Vaccine Consent Form

Recipient Information

Last Name | First Name | Middle Name (optional)

Mother's Maiden Name (Optional) | Date of Birth (MM/DD/YYYY) | Gender

Address | City | State | Zip Code | Phone Number

Emergency Contact Name and Phone Number

Allergies

Pregnant ☐ Yes ☐ No

Language Barrier ☐ Yes ☐ No

Preferred Language

Race:	Ethnicity:		Veteran:	Farmworker Status:	Homeless:	Public Housing:
☐ American Indian ☐ African American ☐ Multiracial	☐ Asian ☐ White ☐ Other	☐ Hispanic ☐ Non-Hispanic	☐ Yes ☐ No	☐ Migrant ☐ Seasonal ☐ Not a Farmworker	☐ Yes ☐ No	☐ Yes ☐ No

Insurance Information

Do you have insurance? ◯ **Yes** ◯ **No**

Plan Name | Plan Group ID # | Plan Individual ID #

Plan Holder Name | Private Insurance Address and Phone Number (If Available)

State ID or Driver's License Number | Social Security Number | Refuse to Provide ☐ Not Applicable ☐

Recipient Printed Name | Recipient Signature | Date Signed

Authorized Person's Printed Name (if applicable) | Authorized Person's Signature | Date Signed

Vaccine Administration Information for Immunizer Use Only

Administration Date | Manufacturer | NDC #

◯ **LEFT ARM** ◯ **RIGHT ARM**

Lot Number | Expiration Date | Route | Site

Administering Immunizer Name and Title | Administering Immunizer Signature

Is this the Recipient's first or second dose? ◯ **First** ◯ **Second**

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Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

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.

Patient Name _____

DOB _____

Preferred Vaccine if Available: ☐ **Moderna** ☐ **J and J**

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
• Polysorbate			
• A previous dose of COVID-19 vaccine			
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 or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? If so, when (date)?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			

Internal use:
Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists