

## 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

	YES	NO	UNKOWN
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or Epi Pen or for which you had to go to the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after any vaccination or injectable medication including a previous dose of the COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. In the past 14 days have you had contact with a confirmed COVID-19 patient?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you breastfeeding or pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you received passive antibody therapy as a treatment for COVID-1?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you immunocompromised? (taking medication or being treated for cancer, leukemia, HIV/AIDS or other immune system problems or taking medication that affects your immune system)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever received a dose of COVID-19 vaccine? When? ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICIP 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 CICIP 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 CICIP and filing a claim is available by calling 1-855-266-2427 or visiting <https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine>

**PLEASE PRINT NAME** of signature below

<b>SIGNATURE OF PATIENT</b>	<b>RELATIONSHIP TO CLIENT</b>	<b>TODAY'S DATE</b>
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#### 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.

<b>Client Signature/Legal Representative</b>	<b>Relationship to Client</b>	<b>Today's Date</b>
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## COVID-19 Vaccination Consent under Emergency Use Authorization

For Clinic Use only

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

### Information for healthcare Professionals about the health history for COVID-19 vaccines

**Are you feeling sick today?** There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (e.g., upper respiratory infections, diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics. Vaccination of persons with current SARS-CoV-2 infection should be deferred until the person has recovered from acute illness and they can discontinue isolation. While there is no minimum interval between infection and vaccination, current evidence suggests reinfection is uncommon in the 90 days after initial infection. Persons with documented acute SARS-CoV-2 infection in the preceding 90 days may delay vaccination until near the end of this period, if desired.

**Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?** Allergic reactions, including severe allergic reactions, NOT related to vaccines or injectable therapies (e.g., food, pet, venom, environmental, or latex allergies; oral medications) are NOT a contraindication or precaution to vaccination with currently authorized COVID-19 vaccine. HOWEVER, individuals who have had severe allergic reactions to something, regardless of cause, should be observed for 30 minutes after vaccination. All other persons should be observed for 15 minutes.

**Have you ever had a serious reaction after any vaccination or injectable medication including a previous dose of the COVID-19 vaccine?** History of severe allergic reaction (e.g., anaphylaxis) to a previous dose or component of the COVID-19 vaccine product being offered is a contraindication to that COVID-19 vaccine

**In the past 14 days have you had contact with a confirmed COVID-19 patient?** Wait until 14 days after quarantine period ends if the contact was in an outpatient or community setting. If person is a resident in a congregate healthcare or other congregate setting go ahead and vaccinate

**Are you breastfeeding or pregnant?** Is not a contraindication to current COVID-19 vaccination. While there are currently no available data on the safety of COVID-19 vaccines in pregnant people, studies and results are expected soon. Pregnant people may choose to get vaccinated. Observational data demonstrate that while the absolute risk is low, pregnant people with COVID-19 have an increased risk of severe illness. Breastfeeding is not a contraindication to current COVID-19 vaccine. Lactating people may choose to be vaccinated. There is no data available for lactating people on the effects of mRNA vaccines.

**Have you received passive antibody therapy as a treatment for COVID-19?** Based on the estimated half-life of monoclonal antibodies or convalescent plasma as part of COVID-19 treatment, as well as evidence suggesting that reinfection is uncommon in the 90 days after initial infection, vaccination should be deferred for at least 90 days, as a precautionary measure until additional information becomes available, to avoid interference of the antibody treatment with vaccine-induced immune responses

**Are you immunocompromised? (taking medication or being treated for cancer, leukemia, HIV/AIDS or other immune system problems or taking medication that affects your immune system)** is not a contraindication to current COVID-19 vaccine, including those with cancer, leukemia, HIV/AIDS and other immune system problems or taking medication that affects their immune systems. However, patients should be informed that the vaccine might be less effective than in someone who is immunocompetent.

**Do you have a bleeding disorder or are you taking a blood thinner?** COVID-19 vaccine may be given to these patients, if a physician familiar with the patient's bleeding risk determines that the vaccine can be administered intramuscularly with reasonable safety. ACIP recommends the following technique for intramuscular vaccination in patients with bleeding disorders or taking blood thinners: a fine-gauge needle (23-gauge or smaller caliber) should be used for the vaccination, followed by firm pressure on the site, without rubbing, for at least 2 minutes.