COVID Immunization Consent Form

NORTHWEST ARKANSAS COUNCIL

Name : _____ Date of Birth: _____ Age: ____ Gender: ☐Male / Female☐

Street Address: _____ City: _____ State: ____ Zip Code: _____

Email Address: _____ @_____ Phone Number: _____

Please contact me about screenings, immunization clinics and other promotions.

Race: ☐White ☐Hispanic/Latino ☐Black/African American

☐Native American /Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐Other

MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine.

If you answer "YES" you may not be able to receive the COVID -19 vaccine.

Section 1: **If YES and further guidance is needed, refer to Pfizer website at www.PfizerMedInfo.com or call 1 -800-438-1985 for vaccine information on vaccine temperature excursions, efficacy, safety, stability, dosage, vaccine ingredients, mechanism of action and administration. For overview for Vaccination Providers about Moderna COVID -19 vaccine refer to www.modernatx.com or call 1-866-MODERNA.*	*YES	NO
Have you had a previous COVID-19 vaccine? If yes, date? Date:_____ Type: ☐Moderna ☐Pfizer	☐	☐
Have you had any vaccines within the previous 14 days? Pfizer-BioNTech or Moderna COVID-19 vaccine should be administered alone with minimal interval of 14 days before or after any other vaccine.	☐	☐
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?	☐	☐
Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component or injectable therapy? (including Pfizer-BioNTech or Moderna COVID-19 vaccine) Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness, and weakness.	☐	☐
Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive Pfizer- BioNTech or Moderna COVID-19 vaccine, a discussion with your healthcare provider can help make informed decision.	☐	☐
Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe obesity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive Pfizer-BioNTech or Moderna COVID-19 vaccine unless otherwise contraindicated.	☐	☐
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Pfizer-BioNTech or Moderna COVID-19 vaccine should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced immune responses.	☐	☐

NOTE: *Depending on vaccine type, a second dose of COVID -19 vaccine* ***may*** *be due in 21 days or 28 days after initial vaccine. Refer to your COVID -19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days or 28 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date.*

Section 2: RELEASE AND ASSIGNMENT:

- **I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID -19 vaccine risks and benefits. To read the Vaccine Recipient Emergency Use Authorization Fact Sheet for each vaccine visit the website www.cvdvaccine.com: or you may also visit the Local Health Unit or private provider to receive a printed copy of the EUA Fact Sheet. To read the Vaccine Recipient Emergency Use Authorization for Moderna COVID-19 vaccine visit the website https://www.fda.gov/media/144638/download or (modernatx.com)**
- **I give consent to this COVID -19 provider/staff for the individual named below to be vaccinated with COVID -19 vaccine.**
- **I hereby acknowledge that I have reviewed a copy of the Provider 's Privacy Notice.**
- **I understand that information about this COVID -19 vaccination will be included in (WebIZ) Arkansas Immunization Information System.**

To My Insurance Carrier(s):

- **I authorize the release of any medical information necessary to process my insurance claim(s).**
- **I authorize and request payment of medical benefits directly to this COVID -19 Provider.**
- **I agree that the authorization will cover all medical services rendered until I revoke the authorization.**
- **I agree that the photocopy of this form may be used instead of the original.**

My signature below indicates I have read, understand and agree to section ***2. Release and Assignment*** *of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).*

Signature of patient or guardian X:_____ Date:_____

Below is for pharmacy documentation

Ultra-cold COVID-19 Vaccine

☒ Pfizer-BioNTech

□ First Dose

□ Second Dose

Lot #:_____ Expiration:_____

Route	Site Code	Dosage mL	MFG Code
☒ IM	☐ RD ☐ LD	0.3 mL	PFR

MFG Codes: PFR=Pfizer, MOD=Moderna, ASZ=AstraZeneca, JSN=Janssen, NVX=Novavax, MSD=Merck

Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA

Administered by: _____ Title: _____ Date Given:_____

Pharmacist Immunization Program
Improving Arkansas wellness.