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PATIENT CONSENT & RELEASE FORM AND SCREENING QUESTIONNAIRE FOR COVID-19 VACCINE

Patient's Full Name (First, MI, Last): _____

Date of Birth: _____Age: _____ Gender (circle one): Male / Female / Other_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Care Doctor: _____ Doctor's Number: _____

Emergency Contact Name and Number: _____

Emergency Contact Person's Relationship: _____

COVID-19 Dose		COVID-19 Vaccine Manufacturer			
☐	1st Dose	☐	Moderna	☐	AstraZeneca
☐	2nd Dose	☐	Pfizer	☐	Johnson & Johnson
		☐	Novavax	☐	Sanofi Pasteur
		☐	Other:		

Screening Questionnaire for Vaccination (if you answer yes, please explain below). Please circle:

1. Are you sick today? Yes No
2. Have you received any vaccinations in the past two weeks? Yes No
3. Have you received passive antibody therapy as treatment for COVID-19? Yes No
4. Have you ever received a dose of COVID-19 vaccine? Yes No
   If YES, which vaccine product?
   - ☐ Pfizer
   - ☐ Moderna
   - ☐ Johnson & Johnson
   - ☐ Another product _____
5. Have you ever had an allergic reaction to a previous dose of COVID-19 vaccine or components such as Polyethylene Glycol or Polysorbate? Yes No
6. Do you have allergies to medications, food, latex, or any vaccine components? Yes No
7. Have you ever had a serious reaction after receiving a vaccination or other injectable medication? Yes No

   - If YES to 7 above, was the serious allergic reaction after receiving a COVID-19 vaccine? Yes No

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- If YES to 7 above, was the serious allergic reaction after receiving another vaccine or other injectable medication? Yes No

8. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? Yes No
9. Do you have a bleeding disorder or are you taking a blood thinner? Yes No
10. Do you have cancer, leukemia, AIDS, or any other immune system problem? Yes No
11. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? Yes No
12. Have you had a seizure or a brain or other nervous system problem? Yes No
13. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? Yes No
14. Do you have dermal fillers? Yes No
15. For women: Are you pregnant or is there a chance you could become pregnant during the next month? Yes No
16. For women: Are you breastfeeding? Yes No

Consent and Waiver: I consent the staff to administer the vaccination mentioned above. I have reviewed the vaccine information provided to me and understand the benefits and risks of receiving this vaccination and choose to assume this risk. I fully release and discharge the vaccination providers and Northern Valley Indian Health, its affiliations and their officers, and employees from any illness, injury, loss, or damage that may result therefrom. I assign payment of authorized insurance benefits due to me to be paid to the Northern Valley Indian Health. I consent to the release of medical information when necessary for billing, reimbursement, and medical protocol. I understand that Northern Valley Indian Health will report any vaccine medications I received to the appropriate state or federal Immunization Information System (IIS), Vaccine Administration Management System (VAMS) and/or other designated vaccine registry. I agree to wait near the vaccination area as designated by NVIH for approximately 15-30 minutes to receive care in case of adverse reaction.

I acknowledge that I have received a copy of the Notice of Privacy Policies of Northern Valley Indian Health. I understand the Notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed and of my rights with respect to my health information.

Patient/Parent/Legal Guardian:

_____/_____Date:_____
(Signature) (Print)

Patient Name:_____DOB:_____

Form 03-29-2021 #COV 0002

COVID-19 Vaccination Patient Record

For Documentation in Vaccine Administration Management System (VAMS)

This document facilitates capture of data required for documentation in VAMS

Section I: PATIENT or PATIENT REPRESENTATIVE to complete this section

Today's Date	**First Name** (Print)*	**Last Name** (Print)*	**Gender** (select one)* ☐ Female ☐ Decline to Specify ☐ Male ☐ Other

Date of Birth*	**Race***	**Address**
Ethnicity* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Not Reported	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Unknown/Not Reported	**County of Residence**
Tribe of Membership		**Phone**

COVID dose: ☐ 1st dose ☐ 2nd dose	**If 2nd dose, enter date and facility of 1st dose:**
COVID-19 Vaccine Screening Questionnaire completed? ☐ Yes ☐ No	**COVID-19 Emergency Use Authorization (EUA) Fact Sheet or Vaccine Information Statement (VIS) received?** ☐ Yes ☐ No

*Field required for Vaccine Administration Management (VAMS) reporting

Section II: To Be Completed By HEALTHCARE PROFESSIONAL Administering Vaccine

Date COVID-19 vaccine administered:	**Facility/Location:**

COVID-19 Vaccine Screening Questionnaire reviewed and vaccination administration deemed appropriate:
☐ Yes ☐ No ☐ Precaution identified and vaccination in an alternate setting needed

COVID dose: ☐ 1st dose ☐ 2nd dose	**COVID-19 Vaccine Manufacturer:** ☐ Moderna ☐ AstraZeneca ☐ Pfizer ☐ Johnson&Johnson ☐ Novavax ☐ Sanofi Pasteur ☐ Other:	**If 2nd vaccine dose, manufacturer of 1st dose:** ☐ Moderna ☐ AstraZeneca ☐ Pfizer ☐ Johnson&Johnson ☐ Novavax ☐ Sanofi Pasteur ☐ Other:	**Lot Number:** **Expiration:**	**Injection volume:** ☐ 0.3mL ☐ 0.5mL

Immunization site: ☐ Right Deltoid ☐ Right Thigh (peds) ☐ Left Deltoid ☐ Left Thigh (peds)	**Date of Vaccine Information Statement (VIS) or Emergency Use Authorization (EUA) Fact Sheet:**	**Administration time:**

Was today's vaccination administration successful? ☐ Yes ☐ No If no, is it possible to reattempt administration? ☐ Yes ☐ No *(this is a default question in VAMS and is likely not applicable to most IHS/Tribal/Urban organizations that are utilizing VAMS)* If vaccination was unsuccessful select reason: ☐ Sick or fever ☐ Inventory Shortage ☐ No longer interested ☐ Other: ☐ Staffing ☐ Contraindication identified ☐ _____	Was any vaccine wasted during administration? ☐ Yes ☐ No **If vaccine wasted select reason:** ☐ Broken Vial/Syringe ☐ Vaccine drawn but not administered ☐ Non-vaccine product (e.g. IG, HBIG, Dil) ☐ Open vial but all doses not administered ☐ Lost or unaccounted for vaccine ☐ Other:

☐ COVID vaccination documentation completed in VAMS
☐ COVID vaccination documentation completed in Patient Medical Record

_____ _____

Signature and Title of Vaccinator **Date**

Instructions for Completing COVID-19 Patient Record
For Vaccine Documentation in Vaccine Administration Management System (VAMS)

Purpose of form:

1. Captures required data for documentation of vaccination into Vaccine Administration Management System (VAMS)
2. Serves as a record of COVID-19 vaccine administered to PATIENT
3. Utilized by sites that do not have electronic health record capable of sending required HL7 message to CDC

Form instructions:

1. Print legibly in all fields using dark permanent ink
2. Section I, to be completed by PATIENT or PATIENT REPRESENTATIVE
3. Section II, to be completed by HEALTHCARE PROFESSIONAL who administers vaccine
4. Information from form must be electronically recorded in VAMS
   a. Documentation in VAMS is to occur within 24 hours of vaccine administration
   b. Vaccine administration must be documented by healthcare professional who administered the vaccine to the recipient
5. Completed form to be placed in Patient Health Record after documentation in VAMS