Med-Call HEALTHCARE

# COVID VACCINATION SCREENING FORM

**Last Name** _____ **First Name** _____ **DOB** _____
**Address** _____ **City** _____ **State** _____ **Zip** _____
**Phone** _____ **Email** _____

**Race:** ☐ American Indian or Alaska Native ☐ Asian ☐ Indian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Other Race ☐ Chinese ☐ Unknown ☐ White

**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

| **Minor Patients (Under 18 Years Old)** | | |
|---|---|---|
| Written or verbal consent for vaccine administration obtained from patient/parent? Yes No | | |
| **Name of Parent/Legal Guardian** | **Phone** | **Signature** |
| | | |

| **Screening Checklist for Contraindications to COVID-19 Vaccinations** | | |
|---|---|---|
| 1. Are you feeling sick today? | Yes | No |
| 2. Have you received ANY vaccines in the last 14 days? | Yes | No |
| 3. Have you ever received a dose of COVID-19 vaccine? | Yes | No |
| **If yes, circle one:** *Pfizer Moderna Janssen Other* | | |
| 4. Have you had severe allergic reaction to mRNA COVID-19 vaccines or their contents: polysorbate or polyethylene glycol? | Yes | No |
| 5. Have you received any monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the last 90 days? | Yes | No |
| 6. Have you had a severe allergic reaction to food, animals, insects or other vaccines? | Yes | No |
| 7. Do you have a weakened immune system caused by HIV, infection and/or do you take immunosuppressive drugs or therapies? | Yes | No |
| 8. Are you pregnant or breastfeeding? | Yes | No |
| 9. Written or digital Emergency Use Authorization Fact Sheet / Vaccine Information Sheet provided to patient/parent? | Yes | No |

**Acknowledgment**

*I acknowledge that I have received, read and understood the Emergency Use Authorization (EAU) fact sheet on the vaccine I have elected to receive. I further acknowledge that I understand the purposes/benefits of my State's vaccination registry ("State Registry") and the applicable Provider may disclose my vaccination information to the State Registry, or to any State or Federal Government agencies such as State, County and local departments of Health including the Federal Department of Health and Human Services, the Centers for Disease Control and Prevention. This includes their respective designees as may be required by law for purposes of public health reporting, or to my health provider enrolled in the State Registry. I also understand that I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the applicable provider: (a) the disclosure of my vaccination information by the applicable Provider to the State Registry; or (b) the State Registry from sharing my vaccination information with ant of my other healthcare providers enrolled in the State Registry. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies or State Registry to the entities and for the purposes described in the Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State Registry, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws or federal law may permit certain disclosures of my vaccination information to or through the State Registry or to Government Agencies as required or permitted by law. I agree that my insurance provider or health plan may be charged for any requested items and services not covered by my benefits. Med-Call Healthcare may contact me, through auto-dialing, pre-recorded calls, texts or any other electronic means regarding vaccine second-dose reminders. I release Med-Call Healthcare from all claims relating directly or indirectly to the administration of the vaccine to myself or to the child.*

*I, the undersigned, certify that all the above information is true and correct to the best of my knowledge.*

**Signature of Patient/Parent/Legal Guardian** _____ **Date** _____