SCL Health COVID-19 Vaccine Clinic Consent to Treat and Screening Questionnaire

Nothing is required to receive a vaccine. When applicable, have your vaccine card & insurance card available.

Last Name:_____ **First Name:**_____ MI: _____

Date of Birth:___/____/____ **Gender:** M / F **Phone #:**____-____-_____ **E-mail:** _____

Address (including city, state, zip): _____

Which dose are you receiving today? ▢ 1st Dose ▢ 2nd Dose ▢ 3rd Dose (immunocompromised) ▢ Booster

Date of last dose: _____ **Brand of previous dose(s):** Pfizer Moderna J&J Unknown N/A

Yes	No	**General Questions** (Please review and complete the day of the vaccine)
		Are you currently ill?
		Have you received treatment for COVID-19 with convalescent plasma or a monoclonal antibody (bamlanivimab or casarivimab/imdevimab) in the last 90 days?
		Have you ever had an anaphylactic reaction (i.e. swelling of throat or mouth, difficulty swallowing, sudden drop in blood pressure) to a vaccine or other injectable medication?
		Have you ever had an anaphylactic reaction (i.e. swelling of throat or mouth, difficulty swallowing, sudden drop in blood pressure) to ANY medication or other allergen (i.e food, environmental)? **NOTE**: if yes - you will be observed for 30 min following administration
		Did you have any serious side effects following a previous dose of COVID-19 vaccine?
		Are you at higher risk of bleeding due to a bleeding disorder or use of an anticoagulant medication?

Yes	No	**FDA/CDC Criteria for Third Dose or Booster Dose (not needed for first and second doses)**
		Do you have any of the following conditions that suppress immunity? (Please mark those that apply) ☐ Active cancer treatment for tumors or cancers of the blood ☐ Received an organ transplant and are taking medicine to suppress the immune system ☐ Received stem cell transplant within the last 2 years or are taking medicine to suppress the immune system ☐ Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome) ☐ Advanced or untreated HIV infection ☐ Active treatment with high-dose corticosteroids or other drugs that may suppress your immune response
		Do you have any of the following that increase risks of COVID-19? (mark all that apply) ☐ Age ≥65 years ☐ Age 18-64 years with underlying medical conditions (cancer, cerebrovascular disease, chronic kidney disease, chronic lung disease, heart conditions, obesity, pregnancy, smoker, neurologic conditions, down syndrome, liver disease, sickle cell disease, thalassemia, substance abuse) ☐ Age 18-64 years who are at increased risk for COVID-19 exposure and transmission

I fully understand and agree to all of the following:

- The COVID-19 vaccine is voluntary. I am making a voluntary request to receive the COVID-19 vaccine.
- I understand that a record of my COVID-19 vaccine administration will be entered into the SCL Health Electronic Health Record, Epic, and COVID-19 vaccine administration records will be able to be viewed by others just like the rest of my Epic medical record.
- I understand that SCL Health may be required by law to report my administration information and basic data to the state vaccine registry and CDC and I consent to SCL Health doing so.
- I understand that I am giving SCL Health permission to release any medical or other information necessary to my physician, my insurance including Medicare, or immunization registry, and as applicable, I authorize SCL Health to process my insurance claims with respect to this vaccination.
- I have received and reviewed the Emergency Use Authorization (EUA) Fact Sheet plus any additional COVID-19 vaccine information that has been provided to me by SCL Health. I understand all of the listed potential risks and benefits of the vaccine and accept the risks and wish to receive a vaccine today.
- I have had a chance to ask questions and all of my questions have been answered to my full satisfaction.
- I attest that all information provided on this form is accurate to the best of my knowledge.

Patient/Guardian Signature Date