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:_____/_____/_____ **Age:** _____ years **Gender:** M / F

Address (including city, state, zip): _____

E-mail: _____ **Phone #:**_____-_____-_____

Which dose are you receiving today?

☐ First Dose ☐ Second Dose ☐ First Booster ☐ Second Booster

Please complete your COVID-19 Vaccine History:

Vaccine History	Brand (Pfizer, Moderna, J&J)	Date Received
First Dose		
Second Dose		
First Booster		
Second Booster		

Yes	No	**General Questions** (Please review and complete the day of the vaccine)
		Are you currently ill?
		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 (myocarditis, anaphylaxis, etc)?
		Are you at higher risk of bleeding due to a bleeding disorder or use of an anticoagulant medication?
		* 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

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 v03292022