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

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

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

Address (city, state, zip): _____

Is today your 1st or 2nd dose? ▢ 1st Dose ▢ 2nd Dose - did you have any serious side effects within 24 hours of your first dose? ▢ Shortness of Breath ▢ Itchy throat/ Throat Tightness ▢ Severe Itching/Rash ▢ Severe Nausea/Vomiting ▢ Other: _____

Yes	No	**Questions** (Please review and complete the day of the vaccine)
		Are you currently ill?
		Have you received any other vaccinations (including the flu shot) in the last 14 days?
		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
		Are you pregnant or lactating?
		Do you have a weakened immune system (i.e. cancer, lupus) or do take medications that suppress your immune system (i.e. steroids)?
		If answered yes to previous anaphylactic reaction, pregnant, lactating or immunocompromised, have you consulted with your provider and have decided to voluntarily receive the vaccine and are aware of the risk and benefits and are willing to accept the risks and continue?

Please tell your vaccinator if:

- You take an anticoagulant medication or you have a bleeding disorder & shouldn't receive intramuscular injections

I fully understand and agree to all of the following:

- The COVID-19 vaccine is voluntary. I am making a voluntary request for both doses of the COVID-19 vaccine and I agree to be vaccinated with both doses of the COVID-19 vaccine.
- I understand that a record of my COVID-19 vaccine administration – both doses - 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.
- I have had a chance to ask questions and all of my questions have been answered to my full satisfaction.

Patient/Guardian Signature Date