☐ PFIZER ☐ MODERNA ☐ JANSSEN

COVID-19 VACCINE SCREENING AND CONSENT FORM

Administration Facility Name/Facility ID: _____

SECTION 1: INFORMATION ABOUT PATIENT (PLEASE PRINT) **EMAIL:** _____

Name: Last: First: Middle Initial:

Date of Birth: Month: Day: Year: **Mobile Phone Number (Patient or Guardian):** ( ) 1234567890

Address: **Apt/Room #:**

City: **State:** **ZIP:**

Name of Legal Guardian: Last: First: Middle Initial:

Sex (Gender assigned at birth)
☐ Female
☐ Male

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

Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Primary Insurance Carrier ID #: _____ Grp #: _____
Insurance Company: _____ Insurance Company Phone #: _____
Insured's Name: _____ Relationship: _____ Insured's Date of Birth: _____

Secondary Insurance Carrier ID #: _____ Grp #: _____
Insurance Company: _____ Insurance Company Phone #: _____
Insured's Name: _____ Relationship: _____ Insured's Date of Birth: _____

Designation of COVID-19 vaccination dose number? ☐ First Dose ☐ Second Dose ☐ Third Dose* ☐ Booster Dose*

SECTION 2: COVID-19 SCREENING QUESTIONS

Please check YES or NO for each question.	Yes	No
1. Do you have today or have you had at any time in the last 10 days a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting or diarrhea?	☐	☐
2. Have you tested positive for and/or been diagnosed with COVID-19 infection within the last 10 days?	☐	☐
3. Have you had a severe allergic reaction (for example, needed epinephrine or hospital care) to a previous dose of this vaccine or to any of the ingredients of this vaccine?	☐	☐

SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE

Please check YES or NO for each question.	Yes	No
4. Do you carry an EpiPen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, foods, vaccines or latex?	☐	☐
5. For women, are you pregnant or is there a chance you could become pregnant?	☐	☐
6. For women, are you currently breastfeeding?	☐	☐
7. Are you immunocompromised or on a medication that affects your immune system?	☐	☐
8. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?	☐	☐
9. Are you a female aged 18 to 49 years old receiving the Janssen (Johnson and Johnson) COVID-19 vaccine?	☐	☐
10. If you are under the age of 18, are you and/or your guardian aware that you are only eligible to receive the Pfizer, Moderna or Novavax vaccine?	☐	☐
11. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive? _____	☐	☐
***12. If you meet one or more of the following:** 1) A third dose (or additional dose if first dose was Janssen [Johnson and Johnson]) for moderately to severely immunocompromised (for example, solid organ transplant recipient, immunosuppressant medications, active treatment for cancer, etc.), if you are at least 5 years of age (for Pfizer-BioNTech COVID-19) or 18 years of age (for Moderna vaccine) and at least 28 days have passed from the completion of your COVID-19 primary series. 2) For the mRNA bivalent booster dose, at least 2 months have passed since the completion of a monovalent COVID-19 vaccine primary series or at least 2 months after receipt of the most recent booster dose with any authorized or approved monovalent COVID-19 vaccine and you are 5 years of age or older (Pfizer-BioNTech COVID-19 vaccine), 6 years of age or older (Moderna COVID-19 vaccine) or are 18 years of age or older (Novavax). 3) For a booster dose of Janssen (Johnson and Johnson), at least 2 months have passed since the initial dose of your Janssen (Johnson and Johnson) COVID-19 vaccination, or at least 2 months after your additional dose if immunocompromised, and you are 18 years of age or older. 4) For a booster dose of Novavax monovalent COVID-19 vaccine, at least six months have passed since the completion of a COVID-19 vaccine primary series for people ages 18 years of age and older.	☐	☐

- I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 5 years of age (for Pfizer vaccine consent only); or (c) legally authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Florida Department of Health (DOH) or its agents to administer the COVID-19 vaccine.
- Pfizer BioNTech COVID-19 vaccine product, Comirnaty, has been fully approved and licensed by the U.S. Food and Drug Administration (FDA for use in individuals 12 years of age and older only. The Moderna COVID-19 vaccine product, Spikevax, has also been fully approved and licensed by the FDA for use in individuals 18 years of age and older only.
- I understand that this product (other than Pfizer and Moderna for usage in ages mentioned above only) has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an Emergency Use Authorization (EUA) to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals either 5–11 years of age (Pfizer only), 6-17 years of age (Moderna only), 12 years and older (Novavax only) or 18 years of age and older (Johnson and Johnson); and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the Food, Drug, and Cosmetic Act unless the declaration is terminated or authorization revoked sooner.
- I understand that if I am a male between the ages of 18-39 with preexisting cardiac conditions, such as myocarditis and pericarditis, that it is recommended for me to discuss the potential benefits and risks associated with receiving an mRNA COVID-19 vaccine with my primary health care provider.
- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the State of Florida, the Florida Department of Health (DOH), the Florida Division of Emergency Management (FDEM) and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.
- I acknowledge that: (a) I understand the purposes/benefits of Florida SHOTS, Florida's immunization registry and (b) DOH will include my personal immunization information in Florida SHOTS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize DOH, FDEM or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to DOH, FDEM or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if DOH invoices me after the time of service, upon receipt of such invoice.
- I acknowledge receipt of the DOH Notice of Privacy Practices.

Signature of Patient or Authorized Representative: _____ **Date:** _____

Print Name of Representative and Relationship to Person Receiving Vaccine: _____

Site (LD/RD)	Route	Manufacturer (MVX)	Lot # Unit of Use/ Unit of Sale	Expiration Date	Date of EUA Fact Sheet
	IM				

Administered at location: Facility name/ID	
Administered at location: Type	
Administration Address:	
CVX (product)	
Sending organization:	

Vaccinator Print Name: _____ **Signature:** _____ **Date:** _____

Vaccine Administering Provider Suffix: _____