For HOPE Staff Staff
Administration Site:
LEFT or **RIGHT Deltoid**
Vaccinator:_________________
Immtrac Number:______________

Last Name ________________ **First Name** _________________ **DOB** ________________

Occupation/Type of Work:____

HOPE Clinic COVID-19 Immunization Screening and Consent Form

1. I have the read the MODERNA/Janssen Johnson & Johnson COVID-19 Emergency Use Authorization Fact Sheet? Yes No
2. History of a severe allergic reaction (e.g., anaphylaxis) to any vaccine that required medical attention in the past? Yes No
3. History of a severe allergic reaction (e.g., anaphylaxis) to any injectable medicine that required medical attention in the past? Yes No
4. History of a severe allergic reaction (e.g., anaphylaxis) to any food, insect, latex that required medical attention in the past? Yes No
5. History of allergy to the following ingredients: messenger ribonucleic acid (mRNA), lipids (SM-102, polyethylene glycol [PEG]2000dimyristoylglycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose, recombinant, replication-incompetentadenovirus type 26expressing the SARS-CoV-2 spike protein, citric acid monohydrate, trisodium citrate dihydrate, ethanol, 2-hydroxypropyl-β-cyclodextrin (HBCD), polysorbate-80, sodium chloride? Yes No No
6. Do you have any of the following health conditions/situations:
   a. High fever or severe illness in the past 7 days? Yes No
   b. Bleeding disorder or are on a blood thinner? Yes No
   c. Immunocompromised or are on a medicine that affects your immune system? Yes No
   d. Pregnant or plan to become pregnant? Yes No
   e. Breast feeding? Yes No
7. Received another COVID-19 vaccine? Yes No If yes, please fill the follow blanks
   a. Date of Vaccine _____________________
   b. Select Brand of Vaccine Received ___PFIZER ___MODERNA
8. Have you had a positive COVID test? Yes No If yes, please fill the following blanks
   a. Date of Positive test __________________
9. Have you received any other vaccinations in the past 14 days including flu shot? Yes No
10. Have you received convalescent plasma for SARS-CoV-2 (COVID) in the last 90 days? Yes No
11. Have you received monoclonal antibody for SARS-CoV-2 (COVID) in the last 90 days? Yes No

12. Vaccine Administration Consent: I request that the COVID-19 vaccination be given to me. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries. I agree to immediately report any significant adverse reaction to my primary care physician. I agree to continue safety practices such as wearing a face mask, social distancing, and frequent hand washing. I understand that protection against COVID-19 may not be effective until at least 14 days after the second dose. I agree to receive the second dose of COVID-19 vaccine in 28 days from the first dose if I am receiving MODERNA covid vaccine. Johnson & Johnson is one dose only at this time. I understand the benefits and risks of the vaccination.

____
Recipient (Signature)

____
Print Name

____
Date / Time