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

HOPE CLINIC
a community health center

Last Name _____ **First Name** _____ **DOB** _____

Occupation/Type of Work:_____

HOPE Clinic COVID-19 Immunization Screening and Consent Form

1. I have the read the Pfizer/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, lipids ((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), N-ditetradecylacetamide, potassium chloride, monobasic potassium phosphate, dibasic sodium phosphate dihydrate?

   Yes ☐ 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 ☐
   f. Have you received any dermal fillers like Botox? 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 ☐ JOHNSON & JOHNSON
8. Have you had a positive COVID test? Yes ☐ No ☐ If yes, please fill the following blank:
   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 and in 21 days for Pfizer Covid vaccine. Johnson & Johnson is one dose only at this time. I understand the benefits and risks of the vaccination.

_____

Recipient (Signature)/Parent/Guardian for Minor

_____

Print Name

_____

Date / Time