

**COVID-19 VACCINE DOCUMENTATION / CONSENT FORM**

**VACCINE CONSENT:** I have been given a copy and have read, or have had explained to me, the information in the FACT SHEET FOR RECIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA) regarding the vaccine checked below. I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request and authorize the release of immunization records for the patient below to any school, health department or other healthcare provider. This authorization is effective for one year after the date listed below. This authorization may be revoked in writing at any time as provided for in the Sedgwick County Notice of Privacy Practices. Sedgwick County may not condition treatment on the signing of this authorization. If this information is disclosed to someone who is not covered by federal privacy regulations, the information is no longer protected by the federal privacy regulations.

**ACKNOWLEDGMENT OF "NOTICE" OF PRIVACY PRACTICES:** I acknowledge that a copy of Sedgwick County's "Notice" of Privacy Practices has been made available to me with the effective date of July 1, 2013.

Sedgwick County Health Department will administer the COVID-19 vaccine regardless of the vaccine recipient's ability to pay COVID-19 vaccine administration fees or health plan coverage status. By signing below you agree to all information provided in the first four sections of this form.

- Moderna COVID-19 Vaccine  
 Pfizer COVID-19 Vaccine

\_\_\_\_\_  
 Signature of Client/Client Representative

\_\_\_\_\_  
 Date

Relationship to Client:       Self       Parent       Guardian       Spouse

**IMMUNIZATION SCREENING QUESTIONNAIRE**

1.	Are you feeling sick today?		Yes	No
2.	Have you ever received a dose of COVID-19 Vaccine?	If yes, which product? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Other Product _____	Yes	No
3.	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?		Yes	No
4.	• Was the severe allergic reaction after receiving a COVID-19 vaccine?		Yes	No
5.	• Was the severe allergic reaction after receiving another vaccine or another injectable medication?		Yes	No
6.	Do you have a bleeding disorder or are you taking a blood thinner?		Yes	No
7.	Have you received passive antibody therapy as treatment for COVID-19?		Yes	No
8.	Have you received any other vaccines in the past 14 days? (Influenza, MMR, etc)		Yes	No

**CLIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

SSN: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender:  Female  Male

RACE       African American       Asian       Native American       Other  
 Hispanic       White       Middle Easterner       Pacific Islander

Hispanic       Yes       No      Language:  English       Spanish       Vietnamese       Other

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

**FAMILY/GUARANTOR INFORMATION (Required if client under 18 or client is not guarantor)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

VACCINE	MVX	CVX	LOT #	EXP DATE	DOSE
<input type="checkbox"/> Moderna, COVID-19 Vaccine, 100mcg/0.5mL	MOD	207			<input type="checkbox"/> 1 <sup>st</sup> Dose <input type="checkbox"/> 2 <sup>nd</sup> Dose
<input type="checkbox"/> Pfizer, COVID-19 Vaccine, 30 mcg/0.3mL	PFR	208			<input type="checkbox"/> 1 <sup>st</sup> Dose <input type="checkbox"/> 2 <sup>nd</sup> Dose

DATE	TIME	EXT	SITE	ROUTE	PATIENT LABEL
		<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Deltoid ( <i>Preferred</i> ) <input type="checkbox"/> Vastus Lateralis	Intramuscular (IM)	
Signature & Title of Vaccine Administrator				Date	

Clerk Initials Check-in: \_\_\_\_\_

Clerk Initials Check-out: \_\_\_\_\_