JIB MEDICAL, P.C.

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COVID-19 IMMUNIZATION
SCREENING AND CONSENT FORM

Recipient Name: _____ **Recipient Date of Birth (DOB):** _____
(Please Print)

Recipient Gender: _____ **Recipient Phone:** (____) _____

*If Parent of a **minor** Recipient (ages 16 or 17) or the Legal Guardian of the Recipient is authorizing vaccine below (please print)*:

Name of Parent or Legal Guardian of Recipient: _____ **Phone/Cell No:** (____) _____

Parent or Legal Guardian's Address: _____

COVID-19 VACCINE SCREENING QUESTIONNAIRE FOR RECIPIENT

		(*Circle one*)		
1.	Are you feeling sick today?	Yes	No	
2.	Have you ever received a dose of COVID-19 vaccine? • If yes, which vaccine product did you receive? …Pfizer-BioNTech …Moderna …Janssen (Johnson & Johnson) …Another Product (i.e., 1 dose Janssen or 2 doses of an mRNA vaccine [Pfizer-BioNTech, Modern])?	Yes	No	Not sure
	• Have you received a complete COVID-19 vaccine series?	Yes	No	Not sure
3.	Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.) • A component of a COVID-19 vaccine, including either of the following: ○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	Yes	No	Not sure
	○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	Yes	No	Not sure
	• A previous dose of COVID-19 vaccine	Yes	No	Not sure
4.	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? *If Yes, when did you receive the last dose*? _____	Yes	No	Not sure
5.	Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)	Yes	No	Not sure
6.	Check all that apply: ☐ I am a female between ages 18 and 49 years old ☐ I am male between ages 12 and 29 years old ☐ I have a history of myocarditis or pericarditis ☐ I had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies			

	☐ I had COVID-19 and was treated with monoclonal antibodies or convalescent serum ☐ I was diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection ☐ I have a bleeding disorder ☐ I take a blood thinner ☐ I have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies ☐ I have a history of heparin-induced thrombocytopenia (HIT) ☐ I am currently pregnant or breastfeeding (Pregnant patients must provide a note from their doctor clearing them to receive the COVID-19 vaccine.) ☐ I have received dermal fillers ☐ I have a history of Guillain-Barré Syndrome (GBS)		
7.	Have you undergone solid organ transplantation, or have been diagnosed with any conditions that are considered to have an equivalent level of immunocompromise?	Yes	No
	• If yes, are you 18 years or older? (You must provide a note from your doctor as proof).	Yes	No
8.	If you received the *Moderna* or *Pfizer* vaccine series at least 6 months ago:		
	a) Are you 65 years or older?	Yes	No
	b) Are you 18 years or older <u>and</u> live in a nursing home or long-term care setting?	Yes	No
	c) Are you 18 years or older <u>and</u> have an underlying medical condition?	Yes	No
	d) Are you 18 years or older <u>and</u> work or live in a high-risk settings?	Yes	No
9.	If you received the Johnson & Johnson vaccine at least 2 months ago, are you 18 years or older?	Yes	No

CONSENT TO COVID-19 VACCINATION

EMERGENCY USE AUTHORIZATION. The Food and Drug Administration (FDA) has made the COVID-19 vaccine available under an "emergency use authorization" (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This COVID-19 vaccine has not undergone the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available is based on the totality of scientific evidence available, showing that known and potential benefits of the COVID-19 vaccine outweigh the known and potential risks.

CONSENT TO COVID-19 VACCINE. I certify that I am the aforementioned (a) Recipient and at least 18 years of age; (b) Parent or Legal Guardian of the minor Recipient (ages 16 or 17); *or* (c) Legal Guardian of the Recipient. I have been provided with the vaccine manufacturer's *Vaccine Information Fact Sheet* for the COVID-19 vaccine that I am receiving ("VIFS") prior to its administration. I have read or had explained to me the VIFS and COVID-19 vaccine and have had a chance to ask questions, which were answered to my satisfaction, and understand the associated benefits and risks of receiving the COVID-19 vaccine. I further authorize release of all information needed (including but not limited to medical records) for public health purposes, including reporting to applicable vaccine registries. I understand that if I experience any side effects or adverse reaction to the COVID-19 vaccine that I should immediately contact my healthcare provider or, if an emergency, call 911. Accordingly, by my signature below, I request and authorize JIB Medical, P.C. and its employees or agents to administer the COVID-19 vaccine to me or to the Recipient as their Parent or Legal Guardian.

***PRINT NAME*:** _____

***AUTHORIZING SIGNATURE*:** _____ **DATE:** _____

FOR JIB MEDICAL USE ONLY

Area Below to be Completed by Authorized Vaccinator

RECIPIENT ELIGIBILITY

Date of Last Dose: _____

1. Has it been 6 months since the patient's last dose of the **Moderna** **or** **Pfizer** COVID-19 vaccine?
   ☐ Yes ☐ No ☐ N/A
2. Has it been 2 months since the patient's last dose of the **Johnson & Johnson** COVID-19 vaccine?
   ☐ Yes ☐ No ☐ N/A

Is the patient 18 years or older and has undergone solid organ transplantation, or been diagnosed with conditions that are considered to have an equivalent level of immunocompromise? ☐ Yes ☐ No

- If yes, did the patient provide proof? ☐ Yes ☐ No

(These patients must receive a **0.5ml** dosage of the third primary Moderna vaccine at least one month following the second dose.)

Recipient provided a vaccine card? ☐ Yes ☐ No ☐ N/A

VACCINE ADMINISTRATION

Vaccine Name	Administration			EUA Fact Sheet Date	Manufacturer & Lot Number
Moderna	☐ 1st Dose	☐ 2nd Dose	☐ 3rd Dose		

Administration Site: ☐ Left Deltoid ☐ Right Deltoid ☐ Left Thigh ☐ Right Thigh

Dosage: ☐ 0.5ml ☐ 0.25ml

☐ I have provided the Recipient (and/or Parent or Legal Guardian, as applicable) with the vaccine manufacturer's ***Vaccine Information Fact Sheet*** and Recipient consent to this vaccination was obtained.

Administered by: _____ **Admin. Date:** _____