COVID-19 VACCINE SCREENING AND CONSENT FORM

SECTION 1: INFORMATION ABOUT YOU (PLEASE PRINT)

Last Name	**First Name**	**Middle Initial**

Date of Birth	**Age in Years**	**Sex (gender assigned at birth)** ___ **Male** ___ **Female**

Race

___ **American Indian or Alaska Native** ___ **Native Hawaiian or Other** ___ **Other Asian** ___ **Other**
___ **Asian** ___ **Pacific Islander** ___ **Other nonwhite**
___ **Black or African American** ___ **White** ___ **Other Pacific Islander**

Address

City	**State**	**Zip Code**

Cell Phone Number

Is this the patient's first or second dose of the COVID-19 vaccination? ___ **1st Dose** ___ **2nd Dose** ___ **Booster**

SECTION 2: COVID-19 SCREENING QUESTIONS

Please check YES or NO for each question	YES	NO
1. Are you sick today?		
2. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
3. Do you carry an Epi-pen for emergency treatment of anaphylaxis?		
4. For women, are you pregnant or is there a chance you could become pregnant?		
5. For women, are you breastfeeding?		
6. Have you had any other vaccination in the previous 14 days?		
7. In the past 90 days, have you received monoclonal antibodies or been diagnosed with COVID-19?		
8. Have you had, in the last 10 days, 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?		

SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE

Please check YES or NO for each question.	YES	NO
9. Do you have allergies or reactions to any medications, foods, vaccines, or latex? Please explain:		
10. Are you immunocompromised or on a medicine that affects your immune system?		
11. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
12. Have you received a previous dose of any COVID-19 vaccine? If yes, please indicate which manufacturer's vaccine you received and date the dose was administered: ___ Moderna COVID-19 vaccine Date administered: ___ Pfizer-BioNTech COVID-19 vaccine ___________________		
13. Did you experience a non-severe allergic reaction within 4 hours of a previous dose of COVID-19 vaccine? Non-severe allergic reactions can include: hives, swelling, redness, wheezing, GI symptoms, etc? If yes, please explain:		

• I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the patient and confirm that the patient is at least 12 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to BJC Healthcare, LLC/Dry Prong Family Clinic, LLC or their agents to administer the COVID-19 vaccine.
• 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 also understand the need for continued masking/social distancing after receiving the COVID-19 vaccination
• I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation and possibly up to 30 minutes if medical provider deems necessary. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
• I acknowledge that: (a) I understand the purposes/benefits of LDH, Louisiana LINKS and (b) will include my personal immunization information in LINKS registry and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
• I acknowledge receipt of the Notice of Privacy Rights.

• I voluntarily elect to receive the COVID-19 vaccination at BJC Healthcare, LLC/DPFC, LLC after carefully considering the risks and benefits.
• BJC Healthcare advised me to consult with my medical provider to discuss my personal risks, benefits, and potential side effects of receiving the COVID-19 vaccination.
• I understand that the COVID-19 vaccinations given at BJC Healthcare will be tracked and reported to LDH, and as otherwise required by the local, state and federal government.

Signature of Patient or Authorized Representative: Date:

____ __________________

Print Name of Representative and Relationship to Person Receiving Vaccine:

SITE (LD/RD)	ROUTE	MANUFACTURER	LOT #	EXP DATE	DATE OF EUA FACT SHEET

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ADMINISTERED BY:	BJC HEALTHCARE, LLC
LOCATION ADDRESS:	641 ROWENA STREET MONTGOMERY, LA 71454
CLINIC PHONE NUMBER:	318-646-3000

VACCINATOR: (print name)	SIGNATURE:	DATE: