ArnotHealth

# COVID-19 Patient Information and Vaccination Sheet

**Today's Date:** _____ **Primary Care Provider:**_____

## PATIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| **Last Name:** | **First Name:** | **MI:** | **Date of Birth:** | **Sex:** ❑ Male ❑ Female ❑ Other |
| **Mailing Address:** | | **City:** | **State:** | **Zip:** |
| **Home Phone #:** | **Cell Phone #:** | **Work Phone #:** | **Email Address:** | |

**Preferred Contact Method (please select only one):** ❑ Home Phone ❑ Mobile Phone ❑ Work Phone ❑ Email

**Office May Leave Message on Voicemail:** ❑ Yes ❑ No

| | | |
|---|---|---|
| **Emergency Contact Name:** | **Phone #:** | **Relationship:** |

## EMPLOYMENT INFORMATION

| | |
|---|---|
| **Employer Name:** | **Occupation:** |

## DEMOGRAPHIC INFORMATION

**Race:** ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Other Pacific Islander ❑ White

**Ethnicity:** ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline **Language Preference:** ❑ English ❑ Spanish ❑ Other

## PRIMARY INSURANCE COMPANY

| | | |
|---|---|---|
| **Insurance Company:** | **Birthdate:** | **Patient's Relationship to Subscriber:** ❑ Self ❑ Spouse ❑ Child ❑ Other |
| **Subscriber Name:** | **Policy ID #:** | |
| | **Group #:** | |

## CONSENT

**Emergency Use Authorization**

The 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 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 vaccine outweigh the known and potential risks. Please note: FDA approved the Pfizer-BioNTech COVID-19 vaccine as a two-dose series in individuals 16 years of age and older. The vaccine continues to be available under an EUA for certain populations, including for those individuals 5 through 15 years of age and for the administration of a third dose in the populations set forth in the consent section below.

**Emergency Use Instruction**

Emergency Use Instructions (EUIs) are issued by the CDC to provide information about emergency use of FDA-approved medical products that may not be included in or differ in some way from the information provided in the FDA-approved labeling (package insert). The COVID-19 vaccine by Pfizer-BioNTech is an FDA-approved COVID-19 vaccine (brand name Comirnaty, mRNA) to prevent COVID-19 in persons 16 years of age and older. CDC is issuing EUI to provide information about use of this vaccine as an additional primary dose in certain immunocompromised persons (12 years of age and older) and a booster dose (12 years of age and older) **who received certain non-FDA authorized or approved COVID-19 vaccine** (e.g., certain vaccines available outside of the United States or from clinical trial participation).

**Consent**

I have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if my vaccine requires two doses, I will need to be administered (given) two doses to be considered fully vaccinated. Further, I understand that a booster dose of COVID-19 vaccine may be recommended at least 2 months following the first dose of Janssen vaccine (for everyone, no restrictions), OR at least 6 months following the second dose of Pfizer-BioNTech or Moderna COVID-19 vaccine if I am 18 years old or older to increase my protection.

I have had a chance to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. 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 plan, Medicare 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.

NEW YORK STATE OF OPPORTUNITY. Department of Health

**Print Name:**_____

**Date of Birth:**_____

| SCREENING QUESTIONS | Yes | No | Unknown |
|---|---|---|---|
| Are you feeling sick today? | ❑ | ❑ | |
| In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure? | ❑ | ❑ | ❑ |
| Have you been treated with antibody therapy for COVID-19 in the past 90 days (3 months)? *If yes, when did you receive the last dose?*_____ | ❑ | ❑ | ❑ |
| Have you ever had an immediate allergic reaction (e.g. hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injection, or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything? | ❑ | ❑ | ❑ |
| Are you pregnant or considering becoming pregnant? | ❑ | ❑ | ❑ |
| Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system? | ❑ | ❑ | ❑ |
| Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments? | ❑ | ❑ | ❑ |
| Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner? | ❑ | ❑ | ❑ |
| Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)? | ❑ | ❑ | ❑ |
| * Have you received 2 doses of the Pfizer vaccine, the second dose being at least 5 months ago? | ❑ | ❑ | |
| * Have you received 2 doses of the Moderna Vaccine, the second dose being at least 5 months ago? | ❑ | ❑ | |
| * Have you received a previous dose of the Janssen Vaccine, at least 2 months ago? | ❑ | ❑ | |
| * If you had a previous dose of Janssen (Johnson & Johnson), did you develop Thrombosis with Thrombocytopenia Syndrome (TTS)? | ❑ | ❑ | ❑ |
| ** Are you 50 years old or older, and have you received 3 doses of the Pfizer or Moderna vaccine, the third dose being at least 4 months ago? | ❑ | ❑ | |
| ** Have you received 2 doses of the Janssen (Johnson & Johnson) vaccine, or 1 dose of the Janssen vaccine and 1 dose of mRNA vaccine, the second dose being at least 4 months ago? | ❑ | ❑ | |
| [1] Have you received a previous dose of a non-FDA authorized or approved COVID-19 vaccine authorized by the WHO[1] but NOT by the FDA (AstraZeneca - VAXZEVRIA, Sinovac - CORONAVAC, Serum Institute of India - COVISHIELD, Sinopharm/BIBP, COVAXIN)? | ❑ | ❑ | ❑ |

***Questions pertain to booster dose eligibility.**

****Questions pertain to the second booster dose eligibility.**

[1] As set forth in the CDC's Emergency Use Instructions, a non-FDA authorized or approved COVID-19 vaccine such as those vaccines "listed for emergency use by the World Health Organization, or is included in CDC's Technical Instructions for Implementing Presidential Proclamation Advancing Safe Resumption of Global Travel During the COVID-19 Pandemic and CDC's Order, or that is a non-placebo part of a clinical trial within or outside the United States that is a WHO-EUL COVID-19 vaccine or a vaccine that is not listed for emergency use by WHO but for which a U.S. data and safety monitoring board or equivalent has independently confirmed efficacy in the United States (hereinafter '"non-FDA authorized or approved COVID-19 vaccines').

**Recipient/Surrogate/Guardian Signature:** _____ **Date:** _____

**Relationship to the patient (if other than the recipient):** _____ **Print Name:** _____

## VACCINE ADMINISTRATION INFORMATION (For Immunizer/Pharmacist use ONLY)

**Which vaccine is the patient receiving today?**

| Vaccine Name | Administration | Fact Sheet Date | Manufacturer & Lot Number |
|---|---|---|---|
| Pfizer/ BioNTech | 0.3/30mcg ❑ First Dose ❑ Second Dose ❑ 3rd Supplemental ❑ 1st Booster ❑ 2nd Booster | | |
| Moderna | 0.5/100mcg ❑ First Dose ❑ Second Dose ❑ Third Supplemental | | |
| Moderna Booster | 0.25/50mcg ❑ 1st Booster ❑ 2nd Booster | | |
| Janssen | 0.5/100mcg ❑ Single Dose ❑ Booster | | |

- I have reviewed side effects with patient (and parent, guardian or surrogate, as applicable)
- I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered correctly and to the best of my ability.

**Administration Site:** ❑ Left Deltoid ❑ Right Deltoid

Vaccinator Printed Name: _____

Vaccinator Signature: _____ Date:_____