PROVIDER COVID-19 IMMUNIZATION CONSENT FORM

For COVID-19 Provider use only Clinic Name/Code: Location type: (clinic, health department, pharmacy, etc.,)_____
Address:_____City:_____County:_____
State:_____ Zip Code: _____ Date of Service:_____

Person Receiving Vaccine:
(Legal) First Name: _____MI: _____ Last Name:_____
Date of Birth: _____/_____/_____ Age: _____

1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. If you answer "YES" you may not be able to receive the COVID-19 vaccine.

If YES refer to following websites at www.PfizerMedInfo.com. Moderna Moderna Covid19 Vaccine (modernatx.com) Investigational Vaccine Candidate | Novavax COVID-19 Vaccine (novavaxcovidvaccine.com) Refer to Prevaccination Checklist for COVID-19 Vaccines Information for Healthcare Professionals (cdc.gov) to clarify questions: Checklist of Current Versions of U.S. COVID-19 Vaccination Guidance and Clinic Support Tools (immunize.org)	*YES	NO
Have you had a previous COVID-19 vaccine? If yes, what **type, number of doses** and **date**? Have you had a (Mpox) JYNNEOS vaccine in last 4 weeks?		
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation?		
Have you ever had an allergic reaction to a COVID-19 vaccine, or COVID-19 vaccine component (including polyethylene glycol [PEG], found in some medications, or laxatives, and preparations for colonoscopy; or polysorbate found in some vaccines, coated tablets, or IV steroids)?		
Have you ever had an immediate allergic reaction that caused hives, swelling, respiratory distress (including wheezing) or anaphylaxis to a vaccine other than COVID-19 vaccine or an injectable medication that required treatment with epinephrine (EpiPen) or treatment at a hospital? Severe reaction or anaphylaxis to food, pet, venom, environmental, or oral medication allergies are not contraindications or precautions to vaccination with any COVID-19 vaccine.		
Have you received a hematopoietic cell transplant (HCT) or CAR-T-cell therapy since receiving COVID-19 vaccine? Follow the COVID-19 vaccine schedule for unvaccinated people. Revaccinate starting at least 12 weeks after transplant or CAR-T-cell therapy with an age-appropriate bivalent Pfizer, Moderna, or monovalent Novavax COVID-19 vaccine.		
Did you develop myocarditis or pericarditis after any dose of COVID-19 vaccine? You should **not** receive a subsequent dose of **any** COVID-19 vaccine. If you have developed myocarditis or pericarditis unrelated to an mRNA COVID vaccination, you may receive age-appropriate bivalent Pfizer, Moderna, or monovalent Novavax COVID-19 vaccine after the episode has completely resolved.		
Are you immunocompromised or receiving immunosuppressive therapy? Do you have a condition that weakens your immune system? You are eligible to receive age-appropriate bivalent Pfizer, Moderna, or monovalent Novavax COVID-19 vaccine unless you have a contraindication to COVID-19 vaccine for some other reason.		
Have you had history of Heparin-Induced Thrombocytopenia (HIT) or Thrombosis with Thrombocytopenia Syndrome (TTS)? You may receive age-appropriate bivalent Pfizer, Moderna, or monovalent Novavax COVID-19 vaccine.		
Have you had history of Thrombosis with Thrombocytopenia Syndrome (TTS) following Janssen or any other adenovirus-vector (AstraZeneca) COVID-19 vaccine? Those who developed TTS after the initial Janssen vaccine should **not** receive a Janssen or any other adenovirus-vector COVID-19 vaccine. You may receive age-appropriate bivalent Pfizer, Moderna, or monovalent Novavax COVID-19 vaccine.		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment or for post-exposure prophylaxis (PEP)? You may receive a COVID-19 vaccine. No delay to receive a COVID-19 vaccine is necessary.		
Have you had Multisystem Inflammatory Syndrome (MIS)? Defer vaccination for at least 90 days. The decision for COVID-19 vaccination should be between the patient, their guardian, clinical team, or a specialist.		
Have you had history of Guillain-Barre Syndrome (GBS)? You may receive age-appropriate bivalent Pfizer, Moderna, or monovalent Novavax COVID-19 vaccine. People who had GBS after receiving Janssen vaccine should receive an age-appropriate bivalent Pfizer, or Moderna COVID-19 or monovalent Novavax vaccine at least 8 weeks after the Janssen dose.		

Note: At the time of initial vaccination, depending on vaccine product, children ages 6mo-4 years are recommended to receive 2 or 3 bivalent doses; children aged 5 years are recommended to receive 1 or 2 bivalent doses. People ages 6 years and older who are unvaccinated or previously received only monovalent vaccine doses are recommended to receive 1 bivalent dose. People 65 years and older may receive 1 additional bivalent dose. Persons 18 years and older who received Janssen COVID-19 Vaccine and have not received a bivalent booster dose are recommended to receive an age-appropriate bivalent mRNA vaccine dose at least 2 months after Janssen dose or at least 2 months after the last monovalent booster dose.

2. **RELEASE AND ASSIGNMENT:** Please read the section on the reverse side of this form**.** The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right.

Please sign here

My signature below indicates I have read, understand, and agree to section **2. Release and Assignment** of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).

Signature of Patient/Parent/Guardian:

_____Date_____

RELEASE AND ASSIGNMENT:

- I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient EUA Fact Sheet for each COVID-19 vaccine visit Coronavirus Disease 2019 (COVID-19) | FDA. You may also visit your Local Health Unit or PCP to receive a printed copy of the EUA Fact Sheet.
- I give consent to this COVID-19 provider/staff for the individual named below to be vaccinated with COVID-19 vaccine.
- I hereby acknowledge that I have reviewed a copy of the Provider's Privacy Notice.
- I understand that information about this COVID-19 vaccination will be included in (WebIZ) Arkansas Immunization Information System.

To My Insurance Carrier(s):

- I authorize the release of any medical information necessary to process my insurance claim(s).
- I authorize and request payment of medical benefits directly to this COVID-19 Provider.
- I agree that the authorization will cover all medical services rendered until I revoke the authorization.
- I agree that the photocopy of this form may be used instead of the original.

PATIENT INFORMATION:

(Legal) First Name: _____ MI: ____ Last Name: _____

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ **Gender:** ☐ Male ☐ Female **Phone #: _____**

Street Address: _____ P.O. Box _____ Apt. No. _____

City: _____State: _____ Zip Code: ☐☐☐☐☐

Race: ☐ Asian ☐ Black/African American ☐ Native American /Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic

INSURANCE STATUS (Check appropriate box):

Patient's Relationship to Insurance Policy Holder: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

☐ **Medicaid/ARKids Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐ **Medicare Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐ **Insurance Company Name**: _____

Member ID/Policy #: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

REQUIRED POLICY HOLDER INFORMATION:

(Legal) First Name: _____ MI: ____ Last Name:_____

Policy Holder Date of Birth: ☐☐ /☐☐ / ☐☐☐☐ **Email Address: _____**

Policy Holder's Employer Name: _____

COVID-19 VACCINE ADMINISTRATION (Completed by staff only)

Co-administration of COVID-19 vaccines and other vaccines including flu vaccine. COVID-19 vaccines and other vaccines **may be administered without regard to timing** (same visit) with the exception of JYNNEOS vaccine. Refer to JYNNEOS Vaccine | Monkeypox | Poxvirus | CDC Refer Interim Clinical Considerations for Use of COVID-19 Vaccines | CDC to the Pre-vaccination Checklist for COVID-19 vaccines to clarify medical history questions: Prevaccination Checklist for COVID-19 Vaccines Information for Healthcare Professionals (cdc.gov)

Ultra-cold COVID-19 Vaccine: Cap Color	**Frozen COVID-19 Vaccine: Label Color**	**Refrigerated COVID-19 Vaccine**
☐ Pfizer 0.2ml Bivalent 6mo- 4yrs (Maroon Cap)	☐ Moderna 0.2mL Bivalent 6mo-5yrs (Yellow Label)	☐ Novavax-Matrix-M1
☐ Pfizer 0.3mL ≥ 12yrs (Gray Cap/Gray Bivalent Label)	☐ Moderna 0.5mL ≥ 12yrs (Gray Bivalent Label)	☐ Other COVID-19 Vaccine
☐ Pfizer 0.2mL 5-11yrs (Orange Cap/Orange Bivalent Label)	☐ Moderna 0.25mL 6-11yrs (Gray Bivalent Label)	
	☐ Moderna 0.25mL 6mo-5yrs (Gray Bivalent Label)	

Route	**Site Code**	**Dosage mL**	**MFG Code**	**Lot Number**	**≥ 6 mo.-4 or 5years Bivalent Dose #**	**≥ 6 years Bivalent Dose #**	**Novavax Dose #**
☐ **IM**					☐**One** ☐**Two** ☐**Three** ☐ **Four**	☐**One** ☐**Two**	☐**One** ☐**Two** ☐ **Booster Dose for ≥ 18 yrs only**

MFG Codes: PFR=Pfizer, MOD=Moderna, ASZ=AstraZeneca, NVX=Novavax, MSD=Merck

Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA

Signature and Title of Vaccine Administrator: _____Date Vaccine Administered:___/ ____/ ___