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.

ACKNOWLEDGWMENT 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 QUESTIONAIRE

1.	Are you feeling sick today?		Yes ☐ No ☐
2.	Have you ever received a dose of COVID-19 Vaccine?	If yes, which product? □ Pfizer □ Moderna □ 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
☐ Moderna, COVID-19 Vaccine, 100mcg/0.5mL	MOD	207			☐ 1st Dose ☐ 2nd Dose
☐ Pfizer, COVID-19 Vaccine, 30 mcg/0.3mL	PFR	208			☐ 1st Dose ☐ 2nd Dose

DATE	TIME	EXT	SITE	ROUTE	PATIENT LABEL
		☐ Right ☐ Left	☐ Deltoid (*Preferred*) ☐ Vastus Lateralis	Intramuscular (IM)	

Signature & Title of Vaccine Administrator **Date**

Clerk Initials Check-in: _____ Clerk Initials Check-out: _____