http://www.regentmedicalcare.com/for-patients/

Consent - COVID-19 Immunization Screening and Consent Form - 6 Months and Older

Name: Last:	First:	Middle Initial:	Temperature:
Date of Birth:	**Phone Number:** ( )	**SS#**	**QB ID#**
Address:		**Apt #:**	
City:	**State:**	**Zip:**	

Sex (Gender assigned at birth)	**Race**	**Ethnicity**
☐ Female ☐ Male	☐ American Indian or Alaska Native ☐ Native Hawaiian or other ☐ Other Asian ☐ Unknown ☐ Asian ☐ Pacific Islander ☐ Other Nonwhite ☐ Black or African American ☐ White ☐ Other Pacific Islander	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Parent/Guardian/ Surrogate (if applicable, please print)	Clinic Where Vaccine is Administered Regent Medical Urgent Care, 16872 N. Cave Creek Rd, Phoenix, AZ 85032

Primary Care Physician Address Phone Number

	Screening Questionnaire			
1.	Are you feeling sick today?	□ Yes	□ No	
2.	Have you ever received a dose of Covid 19 Vaccine? If yes, which vaccine product? ○ Pfizer ○ Moderna ○ Janssen (Johnson & Johnson) ○ Other product: _____	□ Yes	□ No	□ Unknown
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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
	• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	□ Yes	□ No	□ Unknown
	• Polysorbate	□ Yes	□ No	□ Unknown
	• A previous dose of COVID-19 vaccine	□ Yes	□ No	□ Unknown
4.	Have you ever had and an allergic reaction to another vaccine other than COVID 19 or any 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	□ Yes	□ No	□ Unknown
5.	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	□ Yes	□ No	□ Unknown
6.	Have you received any vaccine in the last 14 days?	□ Yes	□ No	□ Unknown
7.	Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	□ Yes	□ No	□ Unknown
8.	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	□ Yes	□ No	□ Unknown
9.	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	□ Yes	□ No	□ Unknown
10.	Do you have a bleeding disorder or are you taking a blood thinner?	□ Yes	□ No	□ Unknown
11.	Are you pregnant or breastfeeding?	□ Yes	□ No	□ Unknown

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 completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Consent

I have been provided with the Vaccine Information sheet or patient fact sheet corresponding to the COVID-19 vaccination that I am receiving. I have read the information provided about the vaccine that I am about to receive. I have been given an opportunity 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 vaccination and I voluntarily assume full responsibility for any reactions that may result. I attest that I am eligible to receive the COVID-19 vaccination at this time based on any jurisdiction-based requirements that apply to me. I understand that I should remain in this area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I

understand that two doses of this vaccine will need to be administered (given) for it to be effective.
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 insurance plan, 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 and employers.

_____

Recipient/Surrogate/Guardian (Signature) | Date / Time | Print Name | Relationship to patient, if other than recipient

To be completed by immunizer				
Vaccine Name	**Administration**		**Administration Site -IM**	
Moderna/ Pfizer/ Janssen (Johnson & Johnson)	□ First Dose	□ Second / Later Dose	□ Left Deltoid	□ Right Deltoid
Dosage	□ 0.5 ml	□ ___ml	**EUA Date**	
Lot Number			**Vaccine Expiration Date**	

□ 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.
□ I have confirmed the patient eligibility based on evidence that the patient has provided

Vaccinator Signature: _____ Printed Name: _____ Date: _____

Time Injected:			**Time Left: _____ or □ Unknown**	
Time patient waited	□ 15 min	□ 20 min	□ 30 min	□ **Refused to wait in office after injection**
Adverse Reactions - Injection Site			**Adverse Reactions - Systemic**	**Adverse Reactions - Systemic**
□ No swelling, redness or pain noted at the injection site			□ No reactions noted during visit	□ Nausea/Vomiting
□ Pain at injection site			□ Fatigue	□ Axillary Swelling/Tenderness
□ Swelling at injection site			□ Headache	□ Fever
□ Erythema at the injection site			□ Myalgia	□ Anaphylaxis
□ Other:			□ Arthralgia	□ Rash
			□ Chills	□ Other

Provider notes (if applicable):

To be completed by immunizer, as required by state immunization registry reporting, only for states listed

State	**Instructions**
MS	Check all fields for patients 18 years and younger
OK	Check *Race and Ethnicity* for all patients. Select *Next of Kin* for patients 18 years of age and younger.

Next of Kin- 18 Years or Younger		
Name:	**Phone:**	**Relationship:**
Address:	**City/State:**	**Zip:**
State of NJ Only		
Prescriber Name:	**Prescriber Address:**	
For CA, MA, MT, NJ, NM, NY, TX (For CA, this indicator means the registry will not share with Universities, Schools, or other agencies.		
Registry Sharing Indicator	□ Yes	□ No