VNA Health Care

COVID-19 Vaccine Consent & Questionnaire – Universal

Date	Recipient temperature	Recipient weight

Patient Information			
Name (please print)		Parent/Guardian (if applicable please print)	
DOB	Gender	Preferred Language	
Address		City State Zip	
Phone Number		Email Address	
Ethnicity (circle one) Hispanic Not Hispanic or Latino Unknown Declined			
Race (circle one) American Indian or Alaska Native Asian Native Hawaiian/Other Pacific Islander Black or African American White Other Race Declined			

Screening Questionnaire (circle one)

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Are you feeling sick today?	Yes	No	
2. Have you ever received a dose of COVID-19 vaccine?	Yes	No	Unknown
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product: _____			
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 caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of the COVID-19 vaccine including either of the following:			
• Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	Yes	No	Unknown
• Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.	Yes	No	Unknown
• A previous dose of COVID-19 vaccine	Yes	No	Unknown

4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an 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 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, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.	Yes	No	Unknown
6. 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
7. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	Yes	No	Unknown
8. 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
9. Do you have a bleeding disorder or are you taking a blood thinner?	Yes	No	Unknown
10. Are you pregnant?	Yes	No	Unknown
11. Are you breastfeeding?	Yes	No	
12. Do you have dermal fillers?	Yes	No	

Additional CDC Screening Questions
Check all that apply to you:

- ☐ Female between ages 18 and 49 years old
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)

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 a 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 for Services

I have been provided with the EUA for the corresponding COVID-19 vaccine(s) that I am receiving. I understand that this vaccine requires two doses, two doses of this vaccine will need to be administered in order for it to be effective. I have read the information provided about the vaccine I am to receive. I have had the chance to ask

questions that were answered to my satisfaction, I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the post vaccine waiting area for at least 15 minutes (30 minutes if necessary) after the vaccination to be monitored for any potential adverse reactions. I understand that if I experience side effects that I should do the following: contact the VNA Health Care or call 911. I request that the vaccine be given to me or to the person for whom I am authorized to make this request.

Disclosure of Records

I understand that VNA Health Care may be required to or may voluntarily disclose all my health information needed to report administration of vaccine and/or other public health purposes, including reporting to applicable vaccine registries.

Consent for Communication

By signing below, I agree to receive future communications from VNA Health Care via email, phone call or text message. If you wish not to receive emails, phone calls or text messages from VNA Health Care.
Please initial here to opt out. _____

_____
Recipient/Guardian Signature

_____
Print Name

_____
Relationship to patient, other than recipient

_____ _____
Date Time

Vaccine Administration – Office Use Only					
Vaccine Location (circle one)					
VNA-Highland	VNA-Indian	VNA-Villa	VNA-Wing	VNA-Mona Kea	VNA-Mobile Clinic
VNA-Bensenville	VNA-Bolingbrook	VNA-Romeoville	VNA-Joliet	VNA-Offsite Clinic	
Vaccine Brand (circle one)					
Moderna – 0.5mL		Pfizer – 0.3mL		Janssen – 0.5mL	
Dose (circle one)	First Dose			Second Dose	
Administration Site (circle one)		Left Deltoid			Right Deltoid
Manufacturer Lot Number:			**Expiration Date:**		
Vaccine Administrator Signature					