UW Medicine
VALLEY
MEDICAL CENTER

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PATIENT COVID-19 VACCINE SCREENING & CONSENT

Patient Name (Last, First): _____ Date of Birth:_____

Have you ever received a dose of COVID-19 vaccine? ☐ Yes ☐ No Date of first vaccine: _____
(Those who received trial vaccine should check with trial sponsors to determine if it is feasible to receive additional doses)

If yes, which vaccine product? ☐ Pfizer (16 yrs. and older) ☐Moderna (18 yrs. and older) ☐Other: _____

Vaccination Screening Questions:

***Recommend discussion with healthcare provider prior to receiving vaccine.

1. Are you sick today? (For example, a cold, fever, or a new illness)	Yes	No
2. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	Yes	No
3. Have you ever had a severe allergic reaction that caused hives, swelling, breathing distress including wheezing, anaphylaxis, or required treatment with epinephrine or EpiPen®, or caused you to go to the hospital within 4 hours of receiving **(see below):**		
a. Any 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
b. Polysorbate?	Yes	No
c. COVID-19 vaccine?	Yes	No
4. Have you ever had a severe reaction after receiving another vaccine or another injectable medication? ☐ **Not applicable (never had severe reaction)**	Yes	No
5. Have you ever had a severe allergic reaction to something such as foods, latex, or medication?	Yes	No
6. Have you received passive antibody therapy as treatment for COVID-19 in the last 90 days?	Yes	No
7. Have you received any vaccinations in the last 14 days, or do you have plans to receive any vaccinations in the next 14 days?	Yes	No
8. * Do you have a weakened immune system caused by something such as HIV infection, cancer, or immunocompromising therapies such as cortisone, prednisone, steroids, anticancer drugs, or other treatments/medications?	Yes	No
9. Do you have a bleeding disorder or take a blood thinner?	Yes	No
10. *Are you pregnant or breast feeding?	Yes	No

☐ I attest that this information is true and accurate.

If patient answers **YES** to any questions above, counseling by a licensed healthcare practitioner (RN, ARNP, PA, MD, or DO) is required. Counseling done by _____ (Printed Name)

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Acknowledgements:

- I have made the decision to receive the COVID-19 vaccine voluntarily and freely. I request that the vaccine be given to me or the stated person named above for whom I am authorized to make this request. I have been provided with the Fact Sheet for Vaccine Recipients and Caregivers for the vaccine that I am receiving, including information about side effects and adverse reactions. I have read or had read to me the information provided about the COVID-19 vaccine.
- I understand the Food and Drug Administration has authorized the emergency use of this vaccine, which is not an FDA approved vaccine. I have had the chance to ask questions that were answered to my satisfaction. I understand the nature, alternatives, benefits, and risks of vaccination, to the extent they are known at this time.
- I understand the COVID-19 vaccine requires two doses and that as with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I understand I may choose to not receive the second dose of vaccine, however if I do not take the second dose, the chance that I will become immune may be reduced.
- I have been asked to participate in the v-safe program, which is an after-vaccination health checker for people who receive COVID-19 vaccines. Visit https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/vsafe.html for more information or call 800-CDC-INFO (800-232-4636).
- I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should contact my provider or call 911.

Authorization to Request Payment:
I authorize Valley Medical Center to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

If Uninsured: You must check the box below to attest the following information is true and accurate:

☐ I do not have any insurance, including but not limited to Medicare, Medicaid, or any other private or government-funded health benefit plan. To have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients please provide either (a) a valid Social Security number, (b) state identification number and state of issuance.

Disclosure of Records:
I understand Valley Medical Center may be required to or may voluntarily disclose my health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries, for purposes of treatment, payment or health care operations. I also understand the provider will use and disclose my health information as described in Valley Medical Center's Notice of Privacy Practices are available on Valleymed.org and search for "your privacy" or via this link: VMC Notice of Privacy.

Documentation:
I have read the EUA Fact Sheet provided regarding the COVID Vaccine and consent to have my COVID vaccine entered in my EPIC record.

_____ Date: _____

(Signature of patient, guardian, or authorized representative)

If you are signing on behalf of the patient, you are stating that you are authorized to provide the required consents on behalf of the patient.

Printed Name of parent, guardian, or authorized representative: _____

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