ADHS COVID-19 Vaccine Consent Form

Use this form in conjunction with the CDC Pre-Vaccination Checklist for COVID-19 Vaccines.

ARIZONA DEPARTMENT OF HEALTH SERVICES

PREPAREDNESS

Patient Information

Last Name | First Name | Middle Name (optional)

Mother's Maiden Name (Optional) | Date of Birth (MM/DD/YYYY) | Gender

Address | Apartment Number | City | State | Zip

◯ **No address available**

Phone Number | SSN or Driver's License/State ID Number

Insurance Information

Do you have insurance? ◯ **Yes** ◯ **No**

Medicare ID Number or SSN

Plan Name | Plan Group ID # | Plan Individual ID #

Name of Person Covered By Plan | Covered Person's Date of Birth | Plan Responsible Person Name

Private Insurance Address and Phone Number (If Available)

ASSIGNMENT OF BENEFITS: I hereby assign to ________________________________ any insurance or other third-party benefits available for the administration fee of the COVID-19 vaccine provided to me. I agree to forward to ________________________________ all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

I agree to allow the health care provider to release information to the Arizona State Immunization Information System (ASIIS) to record that I (or for the person for whom I am authorized to consent) have received this COVID-19 vaccine. This information will help keep track of the manufacturer and doses of the vaccine.

I have had a copy of the Emergency Use Authorization for the COVID-19 vaccine made available to me. I have had a chance to ask questions and I believe I understand the benefits and risks of the COVID-19 vaccines requested. I ask that the vaccines be administered to me or the person for whom I am authorized to make this request.

Patient Printed Name | Patient Signature | Date Signed

Authorized Person's Printed Name (if applicable) | Authorized Person's Signature | Date Signed

Vaccine Administration Information for Immunizer Use Only

Administration Date | Manufacturer | NDC #

Lot Number | Expiration Date | Route | Site ◯ **LEFT ARM** ◯ **RIGHT ARM**

Administering Immunizer Name and Title | Administering Immunizer Signature

Is this the patient's first or second dose? ◯ **First** ◯ **Second**

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name ______________________

Age __________

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.

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of a 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			
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
• A previous dose of COVID-19 vaccine.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
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.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
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?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Form reviewed by ______________________ **Date** ______________