Please print:

Last, First Name: _____

Home Address: _____

_____

Date of Birth: _____

COVID-19 Vaccine Screening and Consent

COVID-19 vaccines have not been formally approved by the FDA; they have been approved for emergency use. You will be having this brand of COVID-19 vaccine:

- ☐ Pfizer (see fact sheet: www.fda.gov/media/144414/download)
- ☐ Moderna (see fact sheet: www.fda.gov/media/144638/download)
- ☐ Johnson & Johnson (Janssen) (see fact sheet: www.fda.gov/media/146305/download)

Health History	**Yes**	**No**	**Unknown**
1. Have you ever had a COVID-19 vaccine?	☐	☐	☐

If you answered Yes: *Which brand did you have? When?*

☐ Pfizer Date of dose #1 _____ Date of dose #2 (if applicable) _____
☐ Moderna Date of dose #1 _____ Date of dose #2 (if applicable) _____
☐ Johnson & Johnson Date of dose #1 _____

	Yes	**No**	**Unknown**
2. Have you ever had a severe allergic reaction (anaphylaxis) after any type of injection (shot) or vaccine?	☐	☐	☐
3. Have you ever been told you that you are allergic to polysorbate, polyethylene glycol (PEG) or any ingredients in the above fact sheet?	☐	☐	☐
4. Have you been told that you have COVID-19 **in the <u>past 14 days</u>**?	☐	☐	☐
5. Have you been around anyone with COVID-19 **in the <u>past 14 days</u>**?	☐	☐	☐
If you answered Yes: *Have you completed your quarantine period (the length of time your care team said you should stay away from others)?*	☐	☐	☐
6. Have you received antibodies or plasma to treat COVID-19 in the **<u>past 90 days</u>**?	☐	☐	☐
7. Have you had Multisystem Inflammatory Syndrome in Children or Adults (MIS-C or MIS-A) due to Covid-19 in the **<u>past 90 days</u>**?	☐	☐	☐
8. Are you feeling sick today?	☐	☐	☐

If you are pregnant, lactating (nursing) or have a weak immune system from medication or a condition, please review this website, www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/specific-groups.html, or talk to your health care provider.

Use of your information: This form is used to document that you received the COVID-19 vaccine(s). This information is stored by the Minnesota Immunization Information Center (MIIC) and will be available to those legally allowed to receive it (health care providers, schools, childcare centers, health departments). For more information, see www.health.state.mn.us/people/immunize/miic/public.html or call 1-800-657-3970.

Payment: Under the federal emergency, the vaccine is free, but your insurance will be billed for giving you the injection (shot). Please provide your insurance information for your visit.

- If you don't have your insurance information *with you*, please call Fairview Clinics 1-888-702-4073 or HealthEast Clinics 651-232-1100.
- If you don't have insurance, we have a process to assist you. We may ask that you provide your state of residence and social security number **or** a state-issued identification or driver's license.

Reported side effects of COVID-19 vaccines

Clinical trials have reported these side effects in some people:

- Injection site reaction (pain, redness or swelling where the shot was given); feeling very tired; headache; joint or muscle pain; chills or fever; feeling sick to the stomach; swollen glands; general sense of feeling unwell. These may not be all of the possible side effects. Other reactions, possibly severe, may become known after the vaccines are more widely used.
- Severe allergic reactions (trouble breathing, swelling of the face and throat, fast heartbeat, bad bodily rash, dizziness and weakness). We will watch you for these symptoms for a short time after getting the vaccine.
- There have been reports of severe blood clots after receiving the Johnson & Johnson (Janssen) vaccine. This is very, very rare—affecting a few people out of every million who receive this vaccine. After a careful safety review, the FDA and CDC agree that the benefits of this vaccine far outweigh the risks.

Tell your care team if you have any side effects that bother you or do not go away. If you have a severe reaction of any kind after receiving the vaccine, call 9-1-1, or go to the nearest Emergency Room.

Consent to be vaccinated

- I understand that I will be receiving the vaccine checked on page 1. There are risks and benefits to having this vaccine. I have read the fact sheet for this vaccine or had it read to me. I have asked my care team any questions I had.
- I understand that I am asking that the COVID-19 vaccine be given to me (or to the person named below, for whom I am authorized to make this request).
- I agree that Fairview Health Services may bill my health plan or other payers on my behalf and may receive payment of allowed benefits.

To be signed prior to or at the time of vaccination:

☞ _____ _____ ____ _____ am / pm
Patient Signature (or Authorized Representative) Date Time

_____ _____
Authorized Representative's Printed Name Relationship to Patient
(An "authorized representative" is a parent or legal guardian of a patient under age 18, or a legal guardian or health care agent of an adult who lacks decisional capacity. Guardians and agents require a copy of the guardianship court order or health care directive.)

To be filled out by health care staff (if an interpreter is used): _____ ____. _____ am / pm
Date Time

_____ _____ _____
Interpreter Name Language ID# (if accessed by phone or video)