Please print: **请以正楷填写：**

Last, First Name:
姓名：_____

Home Address:
家庭住址：_____

_____

Date of Birth:
出生日期：_____

COVID-19 Vaccine Screening and Consent
COVID-19 疫苗筛查及同意书

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:
FDA 尚未正式批准使用这些 COVID-19 疫苗，仅准许将其用于紧急情况。 您将接种此品牌的 COVID-19 疫苗：

Pfizer (see fact sheet)
☐ Pfizer（参见情况说明书：www.fda.gov/media/144615/download）
Moderna (see fact sheet)
☐ Moderna（参见情况说明书：www.fda.gov/media/144710/download）
Johnson & Johnson (Janssen) (see fact sheet)
☐ Johnson & Johnson (Janssen)（参见情况说明书：www.fda.gov/media/146685/download）

Health History **健康史**	***Yes*** **是**	***No*** **否**	***Unknown*** **未知**
1. *Have you ever had a COVID-19 vaccine?* 您是否接种过 COVID-19 疫苗？	☐	☐	☐

If you answered Yes: *Which brand did you have? When?*
若是：您接种的是哪个品牌的疫苗？ 何时接种？

Pfizer ☐ Pfizer	*Date of dose #1* 第 1 剂接种日期_____	*Date of dose #2 (if applicable)* 第 2 剂接种日期（若适用）_____
Moderna ☐ Moderna	*Date of dose #1* 第 1 剂接种日期_____	*Date of dose #2 (if applicable)* 第 2 剂接种日期（若适用）_____
Johnson & Johnson ☐ Johnson & Johnson	*Date of dose #1* 第 1 剂接种日期_____	*Date of dose #2 (if applicable)* 第 2 剂接种日期（若适用）_____

	Yes **是**	***No*** **否**	***Unknown*** **未知**
2. *Have you ever had a severe allergic reaction (anaphylaxis) after any type of injection (shot) or vaccine?* 您在注射任何针剂或接种任何疫苗后是否有过严重过敏反应？	☐	☐	☐
3. *Have you ever been told you that you are allergic to polysorbate, polyethylene glycol (PEG) or any ingredients in the above fact sheet?* 您是否曾被告知，您对聚山梨酯、聚乙二醇 (PEG) 或上述情况说明书所述之任何成分过敏？	☐	☐	☐

4. *Have you been told that you have COVID-19* ***in the past 14 days****?*
   过去 14 天内，您是否被告知感染 COVID-19？ ☐ ☐ ☐

5. *Have you been around anyone with COVID-19* ***in the past 14 days****?*
   过去 14 天内，您是否接触过 COVID-19 患者？ ☐ ☐ ☐

   If you answered Yes: *Have you completed your quarantine period (the length of time your care team said you should stay away from others)?*
   若是：您是否已完成隔离期（您的护理团队要求的应该远离他人的时间段）？ ☐ ☐ ☐

6. *Have you received antibodies or plasma to treat COVID-19 in the* ***past 90 days****?*
   过去 90 天内，您是否接受过治疗 COVID-19 的抗体或血浆？ ☐ ☐ ☐

7. *Have you had Multisystem Inflammatory Syndrome in Children or Adults (MIS-C or MIS-A) due to Covid-19 in the* ***past 90 days****?*
   过去 90 天内，您是否出现过因 Covid-19 引起的儿童或成人多系统炎症综合征（MIS-C 或 MIS-A）？ ☐ ☐ ☐

8. *Are you feeling sick today?*
   您今天是否感到身体不适？ ☐ ☐ ☐

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.
若您怀孕、正在哺乳（哺乳期）或因药物或健康问题而免疫力低下，请参阅本网站 https://chinese.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/specific-groups.html 或咨询您的医疗保健服务机构。

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.*
使用您的信息：本表格用于证明您已接种 COVID-19 疫苗。 这些信息由明尼苏达州免疫信息中心 (MIIC) 存储，并将提供给依法获许接收此类信息的机构（医疗保健服务机构、学校、托儿中心、卫生部门）。欲知详情，请浏览 www.health.state.mn.us/people/immunize/miic/public.html 或致电 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.*
费用支付：在联邦紧急状况下，疫苗免费提供，但会从您的保险中收取注射费。前来接种时请提供您的保险信息。

- *If you don't have your insurance information with you, please call Fairview Clinics 1-888-702-4073 or HealthEast Clinics 651-232-1100.*
- 若您未*携带*相关保险信息，请致电 Fairview Clinics 1-888-702-4073 或 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.*
- 若您没有保险，我们也可通过相关程序提供帮助。我们可能会要求您提供居住州和社保号码**或**州颁发的身份证件或驾驶证。

Reported side effects of COVID-19 vaccines
已报告的 COVID-19 疫苗副作用

Clinical trials have reported these side effects in some people:
据临床试验报告，有些人使用疫苗会产生以下副作用：

- *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.*
- 注射部位反应（注射部位疼痛、发红或肿胀）；感觉很累；头痛；关节或肌肉疼痛；发冷或发烧；胃部不适；腺体肿胀；以及一般的不适感。上述副作用也许还不是疫苗可能产生的所有副作用。在疫苗被广泛接种后，也许还会出现其他可能很严重的反应。

- *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.*
- 严重过敏反应（呼吸困难、面部和喉咙肿胀、心跳加快、全身出现严重皮疹、头晕和虚弱）。在您接种疫苗后，我们会观察一小段时间，看看是否出现这些症状。

- *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.*
- 据报告，在接受 Johnson & Johnson (Janssen) 疫苗后，有出现严重血栓的情况。这是非常、非常罕见的情况，在接受此疫苗的每百万人中，仅会影响少数几人。经过谨慎的安全评估后，FDA 和 CDC 均认为此疫苗的益处远大于其风险。

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.
如果您有任何关于副作用的困扰或副作用未见消除，请告知您的护理团队。如果您在接种疫苗后出现任何严重反应，请拨打 9-1-1，或到最近的急诊室就诊。

Consent to be vaccinated
同意接种疫苗

- *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.*
- 我理解我将接种第 1 页勾选的疫苗。接种此疫苗存在风险，但也有益处。我已阅读或已有人向我宣读此疫苗的情况说明书。我已向我的护理团队询问了我的任何疑问。

- *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).*
- 我理解：我要求为我本人接种 COVID-19 疫苗（或为以下指定人员接种，我有权代此人提出这一要求）。

- *I agree that Fairview Health Services may bill my health plan or other payers on my behalf and may receive payment of allowed benefits.*
- 我同意 Fairview Health Services 代表我向我的健康计划或其他支付方提出费用偿付要求，并收取我可以获得的偿付款项。

To be signed <u>at the time of vaccination</u>:
<u>在接种时</u>签字：

☞

_____	_____	_____	_____
Patient Signature (or Authorized Representative) 患者签字（或授权代表）	*Date* 日期	*Time* 时间	*am / pm* 上午/下午

_____	_____
Authorized Representative's Printed Name 授权代表姓名（正楷）	*Relationship to Patient* 与患者的关系

(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.)
（"授权代表"是 18 岁以下患者的父母或法定监护人，或无决定能力的成年人的法定监护人或医疗照护代理人。监护人和代理人需提供一份法庭监护令或医疗照护指示副本。）

To be filled out by health care staff (if an interpreter is used):
由护理人员填写（若使用翻译人员）：

_____	_____	_____
Date 日期	*Time* 时间	*am / pm* 上午/下午

_____	_____	_____
Interpreter Name 翻译人员姓名	*Language* 语言	*ID# (if accessed by phone or video)* ID#（若通过电话或视像接入）