UNCAS
HEALTH DISTRICT **COVID-19 VACCINE SCREENING AND CONSENT FORM**

SECTION 1: INFORMATION FOR VACCINE RECEIPIENTS (PLEASE PRINT)

Last Name	First Name	Middle Initial
Email Address		

Date of Birth			Age in Years	Sex (Gender assigned at birth)
Month	Day	Year		☐ Male ☐ Female

Race	Ethnicity
☐American Indian or Alaska Native ☐Native Hawaiian or Other ☐Other ☐Asian ☐Pacific Islander ☐Black or African American ☐White	☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Address		
City	State	Zip Code
Cell Phone Number		

Have you ever received a dose of COVID-19 vaccine? ☐Y ☐N Vaccine Type: ☐ Pfizer ☐ Moderna ☐ Janssen

First Dose Date_____ Second Dose DATE_____

SECTION 2: COVID-19 SCREENING

Please check YES or NO for each question.	**YES**	**NO**
1. Are you sick today?		
2. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the *ingredients of this vaccine?		
3. Have you had a severe allergic reaction to something other than a vaccine or injectable therapy such as: food, animal venom, environmental, or oral medication allergies?		
4. Are you a female between the age 18 and 49 years?		
5. Are you a male between ages 12 and 29?		
6. In the past 90 days, have your received monoclonal antibodies or been diagnosed with COVID-19?		

SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE

Please check YES or NO for each question.	**YES**	**NO**
9. Are you pregnant or breastfeeding?		
10. Do you have Dermal Fillers?		
11. Are you immunocompromised or on a medicine that affects your immune system?		
12. Do you have a bleeding disorder or take blood-thinning medication?		
13. Do you have a history of Heparin-induced thrombocytopenia (HIT) or blood clotting disorder?		
13. Do you have a history of myocarditis or pericarditis?		
14. Have you been diagnosed with Multisystem Inflammatory Syndrome after a Covid-19 infection?		
15. Do you have a history of Guillain Barre Syndrome?		

* Polyethylene glycol (PEG), which is found in some medications such as laxatives and preparation for colonoscopy procedures and/or Polysorbate, which is found in some vaccines, film coated tablets and intravenous steroids.

SECTION 4: INFORMED CONSENT

- I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the patient and confirm that the patient is at least **5** years of age; or (c) authorized to consent for the patient named above. Further, I hereby give my consent to the Uncas Health District or their agents to administer the COVID 19 Vaccine.

- I understand that Pfizer-BioNTech (also known as Comirnaty) has been approved for full use by the FDA as of August 23, 2021 for use in individuals **16** years and older and under Emergency Use Authorization for ages **5** years and older.

- I understand that Moderna and Johnson & Johnson (Janssen) have not been approved of or licensed by the FDA but has been authorized for use in individuals 18 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the duration is terminated or, authorization revoked sooner.

- I understand that it is not possible to predict all possible side effects or complications associate with receiving vaccine(s). I understand the risks and benefits associated with the above vaccines and have read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I also understand the need for continued masking/social distancing after receiving the COVID-19 vaccination.

- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation and possibly up to 30 minutes if a medical provider deems necessary. If I experience a severe reaction, I will call 911 or go to the nearest hospital.

- I acknowledge that: (a) I understand the purposes benefits of VAMS, Vaccine Administration Management System and (b) VAMS will include my personal immunization information in VAMS registry, and my personal immunization information will be shared with the Centers for Disease Control and Prevention (CDC) or other federal agencies. (c) my immunization information will also be shared with the CT Immunization registry (CTWiZ).

- I voluntarily elect to receive COVID-19 vaccination after carefully considering the risks and benefits.

- I have been advised to consult with my medical provider to discuss my personal risks, benefits, and potential side effects of receiving the COVID-19 vaccination. I understand that the COVID-19 vaccinations given will be tracked and reported to VAMS and CTWiZ, and as otherwise required by the local, state and federal government.

Signature of Patient or Authorized Representative: _____ Date:_____

Print Name of Representative and Relationship to Person Receiving Vaccine: _____

Representative DOB: ___/___/___

Site (LD/RD)	**Route**	**Manufacturer**	**Lot#**	**Exp Date**	**Date of EUA Fact Sheet**
Covid-19 Vaccine Provider:		Uncas Health District			
Address:		401 W. Thames St., Suite 106, Norwich, CT 06360			
Phone Number:		860-823-1189 Ext 109			
Vaccinator (Print Name)				**Vaccinator** (Signature)	
Provider Credential: (Circle)		RN MD Other _____		**Date**:	