Holzer and Holzer Medical Center- Jackson
COVID-19 Vaccine Medical Screening Tool and Consent

Patient Name: _____
Date of Birth: _____

Section 1 – COVID-19 Screening: Please read and answer the questions below. This should be done on the day of immunization before arrival. Bring this form with you to the vaccination clinic.

COVID-19 Screening Questions	No	Yes	Unknown
1. Have you tested positive for COVID-19 at any point in the past?			
2. In the past two weeks, have you had contact with anyone who tested positive for COVID-19 without recommended Personal Protective Equipment (PPE)?			
3. Have you had new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?			

If you have marked "Yes" or "Unknown" to any above question, please contact Employee Health before arrival to work and the vaccination clinic.

Section 2 – COVID-19 Immunization Screening: Please read and answer the questions below. This should be done before arrival. If you prefer not to answer these questions beforehand, you may be reviewed by a provider at the vaccination clinic to determine vaccination eligibility.

Immunization Screening Questions	No	Yes	Unknown
1. Are you sick today? (Example: a cold, fever, or acute illness)			
2. Do you have allergies or reactions to any foods, medications, vaccines, or latex?			
3. Have you had a serious reaction after receiving a vaccination in the past?			
4. Do you have a history of fainting, particularly with vaccines?			
5. Has a physician or healthcare provider ever cautioned or warned you about receiving a vaccine outside of a medical setting where you can be monitored for a reaction?			
6. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?			
7. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, diabetes, anemia, or other blood disorder?			
8. Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, or other immune system problem?			
9. Do you have a weakened immune system or in the past 3 months, taken a medication such as cortisone, prednisone, steroid, anticancer drug, or radiation treatment?			
10. During the past year, have you received a transfusion of blood or blood product, or have been given immune (gamma) globulin or an antiviral drug?			
11. Are you pregnant or is there a chance you may be pregnant now or in the next month?			
12. Have you received any other vaccination or TB skin test in the past 2 weeks?			
2nd Dose Only			
13. Did you have a reaction (hives, shortness of breath, rash, itching) after the 1st dose of the COVID-19 vaccine? Did you have a different reaction that did not go away after 4 days or started to happen at least 5 days after vaccination?			
14. Have you been told you have any new disease since your 1st dose of the COVID-19 vaccine or had worsening/flare of any disease/condition since your 1st dose?			

Section 3 – Form Review: This section is to be filled out by immunizing staff.

Patient Temperature: _____ Date: _____

Forms Review: If any question above is marked "Yes" or "Unknown" or not filled, send to Provider for review.

Provider Review: Employee has been reviewed and is appropriate to vaccinate: **Yes**_____ **No** _____

Provider Signature: _____ Date: _____ Time:_____

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Section 4 - Consent for Vaccination: Review each statement carefully and initial. Once you have gone through each statement, sign at the bottom.

I have been provided a copy of the FACT SHEET FOR RECIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA) OF COVID-19 VACCINE. I have read and understand the information provided about the vaccine I am to receive. All of my questions have been answered to my satisfaction. **Initial** _____

The benefits of receiving the COVID-19 vaccine is it has been shown to prevent COVID-19 following 2 doses in an ongoing clinical trial; it is unknown how long the duration of protection will last. The risks of vaccination include but are not limited to: injection site pain, tiredness, headache, muscle pain, chills, joint pain, fever, injection site swelling, injection site redness, nausea, feeling unwell, swollen lymph nodes, and rarely may include potential for severe allergic reaction that usually occurs within a few minutes to one hour after getting a dose of the COVID-19 vaccine. I understand these benefits and risks and I voluntarily assume full responsibility for any reactions that may result. **Initial** _____

If I am pregnant or planning to become pregnant, I have discussed the benefits and risks with a provider of receiving the vaccine and had my concerns satisfactorily explained to me. I understand these benefits and risks and I voluntarily assume full responsibility for any reactions that may result. **Initial** _____

I understand that this vaccine has been authorized for use under an Emergency Use Authorization (EUA) which is not an approved vaccine. I further understand that there is no FDA approved alternative vaccine but there may be other COVID-19 vaccines granted similar Emergency Use Authorization by the FDA. **Initial** _____

I certify that the medical information I provided in Section 1 and Section 2 is accurate to the best of my knowledge, and I voluntarily assume full responsibility for any reactions that may result from not answering these questions accurately. **Initial** _____

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 an adverse reaction, that I should alert a healthcare worker in the vaccine administration area for assistance. I understand that after leaving the vaccine administration area, I should contact my provider, go to the emergency room, or call 9-1-1 if I experience any serious adverse reactions. **Initial** _____

I understand that Holzer and Holzer Medical Center- Jackson may be required to disclose my health information to the administering provider, my primary care provider (if applicable), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of care and treatment. **Initial** _____

I voluntarily request that the vaccine be given to me or the individual below for whom I am authorized to make this request.

Printed name of person receiving the vaccine **Date**

Signature of individual or authorized Power of Attorney **Date**

Section 5 - Vaccine Administration Information (For Immunizer/Pharmacy Use Only):

<table>
<tr><td colspan="2">Administration Date _____</td><td colspan="2">Vaccine Manufacturer _____</td><td>EUA/VIS Date _____</td></tr>
<tr><td>Lot # _____</td><td>Exp. Date _____</td><td>Route __IM____</td><td>Volume ____ mL</td><td>Site _Deltoid__
Arm (Circle) R L</td></tr>
<tr><td colspan="3">Immunizer Name and Title
_____</td><td colspan="2"></td></tr>
<tr><td colspan="3">Immunizer Signature
_____</td><td colspan="2">Date_____ Time _____</td></tr>
</table>