COVID-19 VACCINATION CONSENT UNDER EMERGENCY USE AUTHORIZATION

PRE-REGISTRATION PARTICIPANT INFORMATION AND CONSENT

LAST NAME:	FIRST NAME:	MI:	DOB:

SEX: ☐ Male ☐ Female ☐ Transgendered ☐ Other

RACE: ☐ White ☐ Pacific Islander ☐ Asian ☐ Black ☐ None Specified ☐ Refused

HISPANIC ETHNICITY: ☐ Yes ☐ No ☐ Unknown ☐ Refused

ADDRESS:	CITY:	STATE:	ZIP:

HOME PHONE:	CELL PHONE:	EMAIL:

RISK FACTORS (CHEK ALL THAT APPLY):
☐ BMI > 30 ☐ HYPERTENSION
☐ CHRONIC HEART DISEASE ☐ COPD
☐ DIABETES ☐ CHRONIC KIDNEY DISEASE

PLACE OF EMPLOYMENT:	ARE YOU AVAILABLE TO COME TO THE CLINIC SITE IN LESS THAN 1 HOUR?	DATE FORM COMPLETED:

WOULD YOU LIKE A REMINDER NOTIFICATION FOR THE NEXT APPOINTMENT? ☐ Yes ☐ No

If yes, how? ☐ Text Message ☐ Email ☐ Phone Call

PRIMARY CARE PHYSICIAN/PHONE NUMBER:	ADDRESS:

APPOINTMENT TIME AVAILABILITY:
☐ 9-12 ☐ 1-4 ☐ 5-7

IS THERE A DAY DURING THAT WEEK THAT YOU ARE NOT AVAILABLE?

PRECAUTIONS & CONTRAINDICATIONS – Please read and answer EVERY question CAREFULLY.

Are you moderately or severely ill today? (Mild illnesses or taking antibiotics are not reasons to withhold vaccination)	YES	NO	UNKNOWN
Are you allergic to any food or medications? Are you allergic to latex? If yes, please list: _____	YES	NO	UNKNOWN
Have you ever had a serious reaction after a vaccination?	YES	NO	UNKNOWN
In the past 14 days have you… Tested ***positive*** for COVID-19? Had contact with another person with lab confirmed COVID-19?	 YES YES	 NO NO	 UNKNOWN UNKNOWN
In the past year, have you been diagnosed with COVID-19 by a medical provider? If yes, date of diagnosis:_____	YES	NO	UNKNOWN
Are you breastfeeding, pregnant or planning of becoming pregnant in the next 6 months? # weeks pregnant: _____	YES	NO	UNKNOWN
In the past 3 months, have you received a treatment that can affect your immune system? Such as oral steroids (ie prednisone), anticancer medications, radiation, or medications for the treatment of RA, Crohns's disease psoriasis.	YES	NO	UNKNOWN
Do you currently have or have a history of seizures, a neurological condition, or Guillain Barré Syndrome?	YES	NO	UNKNOWN
In the past year, have you received a dose of COVID-19 Vaccine? If yes, when: _____	YES	NO	UNKNOWN

Please remain in clinic for 15 minutes after injection for observation. If you leave, you are doing so against medical advice.

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICP to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The CICP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use of covered countermeasures identified in a PREP Act declaration. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV–2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any such product. Information about the CICP and filing a claim is available by calling 1-855-266-2427 or visiting http://www.hrsa.gov/cicp/.

SIGNATURE:	PRINTED NAME	RELATIONSHIP TO PATIENT:	DATE:

I consent to vaccination administration notification to the ShowMeVax system. ☐ Yes ☐ No Initials: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge and agree that I have received or have been advised of the Missouri Department of Health and Senior Services' Notice
Print Name of Privacy Practices and where I can obtain any revisions made to this Notice.

CLIENT SIGNATURE/LEGAL REPRESENTATITVE:	RELATIONSHIP TO PATIENT:	DATE:

CLINIC USE ONLY

(PLACE LABEL HERE)

VACCINE DATE:	INTRAMUSCULARLY (IM)		DOSE #	
	Left Deltoid	Right Deltoid	☐ 1	☐ 2

EUA FACT SHEET DATE: 12/10/2020 GIVEN? Y N	IMMUNIZER SIGNATURE/TITLE:	INITIALS:

AGENCY:	AGENCY ADDRESS:	CLINIC ADMINISTRATION ADDRESS:
Pettis County Health Center	911 E 16th ST. SEDALIA, MO 65301	911 E 16TH ST. SEDALIA, MO 65301

Revised 01/2021