

**GREATER LAWRENCE FAMILY HEALTH CENTER
 COVID Vaccine Consent and Screening Form**

SECTION 1: INFORMATION ABOUT THE INDIVIDUAL TO RECEIVE VACCINE (PLEASE TYPE OR PRINT)

NAME: _____ DATE OF BIRTH _____ SEX: _____
 STREET ADDRESS (HOME): _____ CHECK BOX IF HOMELESS: DO YOU RESIDE IN PUBLIC HOUSING?
 CITY: _____ STATE: _____ ZIP: _____ PHONE: _____
 ETHNICITY: Hispanic/Spanish/Latino Not Hispanic/Spanish/Latino
 RACE: WHITE AFRICAN AMERICAN ALASKA/NATIVE ASIAN AMERICAN INDIAN OTHER
 PRIMARY LANGUAGE: _____ ARE YOU A MIGRANT OR SEASONAL WORKER: YES NO
 ALLERGIES: _____

SECTION 2: SCREENING FOR COVID-19 VACCINE PRECAUTIONS

	YES	NO
Have you received any other vaccines within the last 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
For those who are getting their second vaccine does, did you have a severe allergic reaction to the first COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
Which vaccine product did you receive? _____		
Are you feeling sick today or do you have a recent known exposure to COVID-19 or have experienced any COVID-19 symptoms in the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a severe allergic reaction to any vaccine, medication or other exposure?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant or breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
Are you immunocompromised?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dermal fillers?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 3: CONSENT

CONSENT FOR VACCINATION: I have read or had explained to me the Emergency Use Authorization sheet for the COVID-19 vaccine and understand the risks and benefits. In receiving this vaccination, I understand that I may experience symptoms of headache, body aches, general malaise and possible fever. This does not indicate a COVID-19 infection or adverse reaction to the vaccine, but rather my body's immune response to the vaccine. **I GIVE CONSENT or have the LEGAL AUTHORITY** to consent on behalf of said individual to receive the COVID-19 vaccine and understand that two doses of the vaccine (21-28 days apart) are needed. I also understand that this vaccine is being administered under the Emergency Use Authorization (EUA) and has not yet received full FDA approval. I will notify my PCP should I experience a severe reaction. I give permission for my insurance company to be billed for the costs of administering the vaccine.

 Signature of Individual Receiving a Vaccine or Parent/Authorized Guardian

 Date

SECTION 4: HEALTH INSURANCE INFORMATION

INSURANCE ID/GROUP #: _____ INSURANCE COMPANY: _____
 RX BIN: _____ MEDICARE PART B (if applicable) _____
 POLICY HOLDER NAME: _____ RELATIONSHIP TO INDIVIDUAL: _____

SECTION 5: VACCINE ADMINISTRATION DOCUMENTATION

MANUFACTURER: _____ LOT #: _____ EXPIRATION DATE: _____
 ADMINISTRATION DATE: _____ SITE: R DELTOID L DELTOID DOSE: 1ST DOSE 2ND DOSE
 ADMINISTERING CLINICIAN: _____ REACTION NOTED YES NO
 NEXT APPOINTMENT? _____



CONSENT FOR MINOR'S VACCINATION:

I agree that:

1. I have the legal authority to consent to have the child _____ vaccinated with the Pfizer-BioNTech COVID-19 Vaccine.
2. I understand I am not required to accompany the child named above to their vaccination appointment and that, by giving my consent below, the child will receive the Pfizer-BioNTech COVID-19 Vaccine whether or not I am present at the vaccination appointment.
3. If I am not accompanying the child named above to their vaccination appointment, I will provide a completed pre vaccination screening form, available at: <https://glfhc.org/covid-19-vaccine-signup-form/>
4. If I have health insurance that covers the child named above, I give permission for my insurance company to be billed for the costs of administering the Pfizer- BioNTech COVID-19 Vaccine. The government is paying for the Pfizer-BioNTech COVID-19 Vaccine itself, and I will not be billed for that portion of the cost of my immunization.
5. I understand that as required by state law, all immunizations will be reported to the Department of Public Health Massachusetts Immunization Information System (MIIS). I can access the MIIS Fact Sheet for Parents and Patients, at www.mass.gov/dph/miis, for information on the MIIS and what to do if I object to my or my family's data being shared with other providers in the MIIS.

I GIVE CONSENT for the child named at the top of this form to get vaccinated with the Pfizer-BioNTech COVID-19 Vaccine and have reviewed and agree to the information above (If this consent is not signed, dated and returned, the child will not be vaccinated.)

Signature of Legally Authorized Representative

Date