Vaccine Consent and Screening

The following questions will help us determine if there is any reason you should not get the vaccine(s) today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask the provider to explain it. Information collected on this form is voluntary and confidential. **Please Print.**

Client Last Name: _____ **First Name:** _____ **MI:**____

Age: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female ☐ Other

Address:_____ **City:**_____ **Zip:**_____ **Telephone:**_____

Email: _____ **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

Race: ☐ Black/African American ☐ American Indian ☐ Asian ☐ White ☐ Other race

Insurance Carrier: _____ **Member ID Number**:_____

Insurance Subscriber Name: _____ **Subscriber Date of Birth:** _____

Which vaccine(s) are you interested in receiving today? ☐ Flu vaccine ☐ COVID vaccine

Questions for person receiving vaccine	**Yes**	**No**
1. Have you tested positive for COVID-19 or been exposed to an individual who tested positive for COVID-19 in the past 14 days?	☐	☐
2. Have you received antibody therapy, monoclonal antibodies, or convalescent plasma/serum for COVID treatment in the past 90 days?	☐	☐
3. Are you sick today?	☐	☐
4. Have you ever had Guillain-Barre Syndrome?	☐	☐
5. Have you ever received a COVID-19 vaccine? *If yes, date*: *Type/Brand*:	☐	☐
6. Do you have any allergies or have you had a serious reaction to something, including a vaccine? *Type of reaction*: *Cause*:	☐	☐

CONSENT FOR VACCINATION. Information collected on this form will be used to document authorization for receipt of vaccines. The information will be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. As required by privacy regulations, I hereby acknowledge that I have received or reviewed a current copy of this provider's "Notice of Privacy Practices".

I have been given a copy and have read/or have had explained to me the Vaccine Information Sheet, Vaccine Fact Sheet or FDA Emergency Use Authorization Fact Sheet for the vaccine(s) (the "fact sheet"). I have read the fact sheet and have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of this vaccine and ask that the vaccine be given to me or the person for whom I am authorized to make this request. I understand that for the COVID-19 Moderna and Pfizer vaccines, two doses of the vaccine are recommended as described in the fact sheet. **I have been advised to wait for 15-30 minutes of observation after receiving my COVID-19 vaccine before leaving.**

CONSENT TO BILL INSURANCE. You have my permission to bill my insurance provider for the administration fee for this COVID-19 vaccination. I authorize the release of information to my insurance provider needed to complete and verify payment. I understand that there will be no cost to me for this vaccine.

Print Parent/Guardian Name, if different from client:_____ **Date:**_____

Client/Parent/Guardian Signature:_____ **Date:**_____

FOR OFFICE USE ONLY				
Vaccine	**Site**	**Dose**	**Trade name/Manufacturer Lot Number**	**Expiration Date**
COVID-19	RD LD	1 2 3 Booster		
Influenza	RV RD RV LD	1 2 B		
Signature and Title – Person Administering Vaccine:_____ Date:_____				