ARKANSAS DEPARTMENT of HEALTH (ADH) COVID-19 IMMUNIZATION CONSENT FORM

For COVID-19 Provider use only Clinic Name/Code: _____
Location type:(clinic, health department, pharmacy, etc.,)_____
Address: _____City:_____ County: _____
State:_____ Zip Code: _____ Date of Service:_____

Person Receiving Vaccine:

(Legal) First Name: _____ MI: ____ Last Name: _____

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ **Age: _____**

1. **MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. If you answer "YES" you may not be able to receive the COVID-19 vaccine.**

ADH staff: *If YES and further guidance is needed, notify your local Communicable Disease Nurse Specialist (CDNS).	***YES**	**NO**
Have you had a previous COVID-19 vaccine? If yes, what type and date?		
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?		
Have you ever had an allergic reaction to a COVID-19 vaccine, or a COVID-19 vaccine component (including polyethylene glycol [PEG], found in some medications, or laxatives, and preparations for colonoscopy; or polysorbate found in some vaccines, coated tablets, or IV steroids)?		
Have you ever had an allergic reaction that caused hives, swelling, respiratory distress (including wheezing) or anaphylaxis to a vaccine other than COVID-19 vaccine or an injectable medication that required treatment with epinephrine (EpiPen) or treatment at a hospital? Severe reaction or anaphylaxis to food, pet, venom, environmental, or oral medication allergies are not contraindications or precautions to vaccination with any COVID-19 vaccine.		
Do you have a bleeding disorder or are you taking a blood thinner?		
Have you received a hematopoietic cell transplant (HCT) or CAR-T-cell therapy since receiving COVID-19 vaccine? You should be revaccinated with a primary vaccine series at least 12 weeks after transplant or CAR-T-cell therapy.		
Did you develop myocarditis or pericarditis after any dose of COVID-19 vaccine? You should not receive a subsequent dose of any COVID-19 vaccine. If you have developed myocarditis or pericarditis unrelated to an mRNA COVID vaccination, you may receive COVID-19 vaccine after the episode has completely resolved.		
Are you immunocompromised? Do you have a condition that weakens your immune system? Are you receiving any immunosuppressive therapy? You are eligible to receive any FDA-authorized or FDA-approved COVID-19 vaccine unless you have a contraindication for some other reason. However, you will need special counseling about the vaccine.		
Have you had history of Heparin-Induced Thrombocytopenia (HIT) or Thrombosis with Thrombocytopenia Syndrome (TTS)? You may receive Pfizer-BioNTech or Moderna COVID-19 vaccine.		
Have you had history of Thrombosis with Thrombocytopenia Syndrome (TTS) following Janssen or any other adenovirus-vector (AstraZeneca) COVID-19 vaccine? Those who developed TTS after the initial Janssen vaccine should not receive a Janssen or any other adenovirus-vector COVID-19 vaccine booster dose. You may receive a mRNA COVID-19 vaccine.		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment or for post-exposure prophylaxis (PEP)? You may receive a COVID-19 vaccine. No delay to receive a COVID-19 vaccine is necessary.		
Have you had Multisystem Inflammatory Syndrome (MIS)? Defer vaccination for at least 90 days. The decision for COVID-19 vaccination should be between the patient, their guardian, clinical team, or a specialist.		
Have you had history of Guillain-Barre Syndrome (GBS)? People with a history of GBS can receive any FDA-authorized or approved COVID-19 vaccine. People who had GBS after receiving Janssen vaccine should receive a Pfizer-BioNTech or Moderna COVID-19 vaccine booster at least 8 weeks after the Janssen dose.		

Note: CDC has made a clinical preference for persons 18 years and older to receive an mRNA COVID-19 vaccine over Janssen COVID-19 vaccine. Patients who cannot or are unwilling to receive an mRNA vaccine will be able to access Janssen COVID-19 vaccine. The Janssen Fact Sheet must be provided and explained to the recipient or parent/legal representative about the risks and benefits and address any questions or concerns that the recipient or parent/legal representative may have prior to the vaccination. Recipients of Janssen COVID-19 vaccine should seek immediate medical attention if they develop shortness of breath, chest pain, leg pain or swelling, persistent abdominal pain, severe or persistent headaches or blurred vision, easy bleeding beyond the vaccination site within 30 days of a Janssen vaccination.

Note: A second dose of COVID-19 vaccine **may** be due in 21 days or 28 days after initial vaccine. Refer to your COVID-19 vaccination record card for proof of initial vaccine date and for second dose due date. Contact your vaccination provider, PCP, or your ADH Local Health Unit in 21 days or 28 days for more information.

2. **RELEASE AND ASSIGNMENT:**
Please read the section on the reverse side of this form**.** The Providers Privacy Notice is available at the clinic site or accompanies this form.
Then sign in the box at right. **Please sign here.**

My signature below indicates I have read, understand, and agree to **Section 2. Release and Assignment of the COVID-19 Immunization Consent Form** and **Vaccine Recipient Emergency Use of Authorization (EUA) Fact Sheet**.
Signature of Patient/Parent/Guardian:

_____Date_____

RELEASE AND ASSIGNMENT:

- I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient EUA Fact Sheet for Pfizer COVID-19 vaccine, Moderna COVID-19 vaccine, or Janssen COVID-19 vaccine visit https://www.cdc.gov/vaccines/covid-19/eua/index.html https://www.modernatx.com/covid19vaccine-eua/or you may also visit your Local Health Unit or PCP to receive a printed copy of the EUA Fact Sheet.
- I give consent to this COVID-19 provider/staff for the individual named below to be vaccinated with COVID-19 vaccine.
- I hereby acknowledge that I have reviewed a copy of the Provider's Privacy Notice.
- I understand that information about this COVID-19 vaccination will be included in (WebIZ) Arkansas Immunization Information System.

To My Insurance Carrier(s):

- I authorize the release of any medical information necessary to process my insurance claim(s).
- I authorize and request payment of medical benefits directly to this COVID-19 Provider.
- I agree that the authorization will cover all medical services rendered until I revoke the authorization.
- I agree that the photocopy of this form may be used instead of the original.

PATIENT INFORMATION:

(Legal) First Name: _____ **MI:** ____ **Last Name:** _____

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ **Gender:** ☐ Male ☐ Female **Phone #:** _____

Street Address: _____ **P.O. Box** _____ **Apt. No.** _____

City: _____ **State:** _____ **Zip Code:** ☐☐☐☐☐

Race: ☐ Asian ☐ Black/African American ☐ Native American /Alaska Native ☐ Native-Hawaiian/Other Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic ☐ non-Hispanic

INSURANCE STATUS (Check appropriate box):

Patient's Relationship to Insurance Policy Holder: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

☐ **Medicaid/ARKids Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐ **Medicare Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐ **Insurance Company Name**: _____

Member ID/Policy #: ☐☐☐☐☐☐☐☐☐☐☐☐☐

REQUIRED POLICY HOLDER INFORMATION:

(Legal) First Name: _____ **MI:** ____ **Last Name:** _____

Policy Holder Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ **Email Address:** _____

Policy Holder's Employer Name: _____

COVID-19 VACCINE ADMINISTRATION (Completed by staff only) ADH Immunization Section @ 501-537-8969.

Co-administration of COVID-19 vaccines and other vaccines including flu vaccine. COVID-19 vaccines and other vaccines **may be administered without regard to timing.** This includes simultaneous administration of COVID-19 vaccines and other vaccines during the same visit. Other vaccines can also be administered any time before or after COVID-19 vaccination. Refer to the Pre-vaccination Checklist for COVID-19 vaccines to clarify medical history questions:www.cdc.gov/vaccines/covid-19/downloads/pre-vaccination-screening-form.pdf. Refer to Summary Document of Interim Clinical Considerations Summary Document for Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized or Approved in the United States – Fact Sheet (cdc.gov).

Ultra-cold COVID-19 Vaccine	**Frozen COVID-19 Vaccine**	**Refrigerated COVID-19 Vaccine**
☐ *Pfizer 0.3mL Primary ≥ 12 yrs (Gray Cap)*	☐ *Moderna 0.5mL Primary ≥12 yrs (Light Blue Label)*	☐ AstraZeneca
☐ *Pfizer 0.2mL Primary and Booster 5- 11yrs (Orange Cap)*	☐ *Moderna 0.5mL Primary 6-11yrs (Purple Label)*	☐ Novavax-Matrix-M1
☐ *Pfizer 0.2mL Primary 6 mo-4yrs (Maroon Cap)*	☐ *Moderna 0.5mL Primary 6-11yrs (Teal label)*	☐ Janssen (Johnson & Johnson)
☐ *Pfizer 0.3mL Bivalent ≥ 12 yrs (Gray Cap)*	☐ *Moderna 0.25mL Primary 6mo-5yrs (Magenta label)*	☐ Other COVID-19 Vaccine ____
	☐ *Moderna 0.5mL Bivalent ≥ 18 yrs (Gray Label)*	

Route	**Site Code**	**Dosage mL**	**MFG Code**	**Lot Number**	***Primary Dose*** ☐ ***One*** ☐ ***Two*** ☐ ***Three***	***Bivalent Booster Dose*** ☐ ***One***
☐ **IM**					***Booster Dose*** ☐ ***One***	

MFG Codes: PFR=Pfizer-BioNTech, MOD=Moderna, ASZ=AstraZeneca, JSN=Janssen, NVX=Novavax, MSD=Merck

Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA

Signature and Title of Vaccine Administrator: _____**Date Vaccine Administered:** ___/___/____

Initial Here: ☐ Vaccine Administrator acknowledgment of providing the most current Janssen COVID-19 Fact Sheet to vaccine recipient (explaining the risk and benefits) and addressing any questions or concerns with the vaccine recipient prior to vaccination with Janssen COVID-19. *FORM 4133 Revised 9/7/22/22*