COVID-19 Vaccination Consent Form

Last Name *(Please print)*	First Name	MI	Date of Birth	⌋ Male ⌋ Female ⌋ Other	
Address		City		State	Zip
Phone Number	Email		Name of Primary Care Provider		

SCREENING FOR VACCINATION ELIGIBILITY		
1. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any vaccine or injectable therapy, or a history of anaphylaxis due to any cause?	Yes	No
2. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of a COVID-19 vaccine, including lipid nanoparticles or polyethylene glycol (PEG)?	Yes	No
3. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?	Yes	No
4. Are you under age 12?	Yes	No
5. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?	Yes	No
6. Do you have a bleeding disorder or are you taking a blood thinner?	Yes	No
7. Have you tested positive for COVID-19 in the last 10 days?	Yes	No
8. Are you currently in quarantine for COVID-19 exposure?	Yes	No
9. Have you been diagnosed with Multisystem Inflammatory Syndrome in adults or children in the last 90 days? (If you answer yes to this question, it is recommended you consult with your physician prior to receiving the COVID-19 vaccine)	Yes	No
10. Have you ever been diagnosed with myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the outer lining of the heart)?	Yes	No
11. If this is your second dose, when was the date of your first dose?	/ /	
12. If this is your second dose, which vaccine did you receive (Pfizer, Moderna, etc.)?		
13. Are you moderately to severely immunocompromised?	Yes	No
14. If this is your third dose or booster dose, when was the date of your second dose?	/ /	
15. If this is your third dose or booster dose, which vaccine did you receive (Pfizer, Moderna, etc.)?		
CONSENT FOR VACCINATION		

I will/have reviewed my answers to the questions above with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization (EUA) Fact Sheet or Vaccine Information Statement (VIS) provided to me today. I understand the benefits and risks of the vaccine. I understand that I can review a Notice of Privacy Practice at the time of vaccination.

By signing this form, I give permission for a vaccine to be administered to the person above and a record of the vaccination to be entered into the Rhode Island Child and Adult Immunization Registry (RICAIR) for care coordination and to monitor statewide vaccination coverage. For more information about RICAIR, please go to https://health.ri.gov/ricair. Further, I agree that the information above is correct.

Signature of Parent/Guardian/Patient_____ Date_____

FOR ADMINISTRATIVE USE ONLY **EUA or VIS Date:**

Vaccine	**Date Vaccination and EUA/VIS Given:**	**Route** **IM** *R L*	**Manufacturer**	**Lot No.**	**Printed Name and Signature of Vaccine Administrator**

INFORMATION FOR HEALTH CARE PROFESSIONALS ABOUT VACCINATION ELIGIBILITY

1. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to a vaccine or injectable therapy, or a history of anaphylaxis due to any cause?
   IF YES: Please ask the patient whether they discussed vaccination with a medical provider. If they have, allow vaccination to proceed. Vaccine providers should observe patients after vaccination to monitor for the occurrence of immediate adverse reactions:
   - **Persons with a history of anaphylaxis: 30 minutes**
   - **All other persons: 15 minutes**

2. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of the vaccine, including lipid nanoparticles or polyethylene glycol (PEG)?
   IF YES: Do Not Vaccinate

3. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?
   IF YES: Do Not Vaccinate

4. Are you under age 12?
   FOR PFIZER VACCINE, IF YES: Do Not Vaccinate
   FOR MODERNA OR JOHNSON & JOHNSON VACCINE, IF UNDER AGE 18: Do Not Vaccinate

5. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?
   IF YES: Have patient discuss existing symptoms with a medical provider.

6. Do you have a bleeding disorder or are you taking a blood thinner?
   IF YES: Have patient discuss with a medical provider. ACIP recommends the following technique for intramuscular vaccination in patients with bleeding disorders or taking blood thinners: a fine-gauge needle (23-gauge or smaller caliber) should be used for the vaccination, followed by firm pressure on the site, without rubbing, for at least 2 minutes.

7. Have you tested positive for COVID-19 in the last 10 days?
   IF YES: Do Not Vaccinate

8. Are you currently in quarantine for COVID-19 exposure?
   IF YES: Do Not Vaccinate

9. If this is your second dose, when was the date of your first dose?
   Do Not Vaccinate if less than 17 days ago for Pfizer, or less than 24 days ago for Moderna.

10. Have you been diagnosed with Multisystem Inflammatory Syndrome in adults or children in the last 90 days?
    IF Yes: Have patient discuss with a medical provider.

11. Have you ever been diagnosed with myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the outer lining of the heart)?
    IF YES: Have patient discuss with their clinical team, which may include a cardiologist.

12. If this is your second dose, which vaccine did you receive (Pfizer, Moderna, etc.)?
    Ensure that the second dose is from the same manufacturer as the first dose. **If different: Do Not Vaccinate.**

13. Are you moderately to severely immunocompromised?
    If yes, patient is eligible for a third dose.

14. If this is your third dose or booster dose, when was your second dose?
    Ensure that the third dose or booster dose is 28 days after the second dose.

15. If this is your third dose or booster dose, which vaccine did you receive (Pfizer, Moderna, etc.)?
    Ensure that the third dose or booster dose is from the same manufacturer as the first and second dose.