BREVARD HEALTH ALLIANCE
COVID-19 VACCINE SCREENING AND CONSENT FORM
COVID-19 VACCINE

SECTION 1: INFORMATION ABOUT YOU (PLEASE PRINT)

Last Name	First Name	Middle Name

Date of Birth			Age in Years:	Sex (Gender assigned at birth)
Month	Day	Year		☐ Male ☐ Female

Race
☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Native Hawaiian or Other
☐Pacific Islander
☐White
☐Other Asian
☐Other Nonwhite
☐Other Pacific Islander
☐Other

Ethnicity
☐Hispanic or Latino
☐Not Hispanic or Latino
☐Unknown

Address

City	State	Zip Code

Cell Phone Number

Have you ever received a dose of COVID-19 vaccine?
• If yes, which vaccine product did you receive?
☐Pfizer ☐Moderna ☐Janssen (Johnson & Johnson) ☐ Another product

Is this the patient's first or second dose of the COVID-19 vaccination? ☐ First Dose ☐ Second Dose

SECTION 2: COVID-19 SCREENING QUESTIONS

Please check YES or NO for each question.	YES	NO
1. Are you sick today?		
2. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
3. Do you carry an Epi-pen for emergency treatment of anaphylaxis?		
4. For women, are you pregnant or is there a chance you could become pregnant?		
5. For women, are you breastfeeding?		
6. Have you had any other vaccinations in the previous 14 days?		
7. In the past two weeks, have you tested positive for COVID-19?		
8. Have you had, in the last 10 days, fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?		
9. Do you have dermal fillers?		
10. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?		

SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE

Please check YES or NO for each question.	YES	NO
9. Do you have allergies or reactions to any medications, foods, vaccines, or latex? Please explain:		
10. Are you immunocompromised or on a medicine that affects your immune system?		
11. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
12. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive:		

Three COVID-19 vaccines are currently authorized for use in the United States. These vaccines are authorized for use among different age groups.

PRODUCT AUTHORIZED AGE GROUPS * Anyone outside the authorized age groups for a product should not receive the vaccine.**

- Pfizer-BioNTech COVID-19 Vaccine 12 years of age and older
- Moderna COVID-19 Vaccine 18 years of age and older
- Janssen COVID-19 Vaccine (Johnson & Johnson) 18 years of age and older
- I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the patient and confirm that the patient is at least 16 years of age (for Pfizer, otherwise 18 years of age); or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Brevard Health Alliance (BHA) or its agents to administer the COVID-19 vaccine.
- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). COVID-19 Vaccine side effects that have been reported in clinical trials include, but are not limited to: injection site pain • tiredness • headache • muscle pain • chills • joint pain • fever • injection site swelling • injection site redness • nausea • feeling unwell • swollen lymph nodes (lymphadenopathy). Certain severe allergic reactions have been reported outside of clinical trials; if you develop symptoms of an allergic reaction following vaccination (such as trouble breathing, chest pain or a fast heartbeat, dizziness, weakness, swelling of the face, throat, or tongue, or a rash all over your body), call 911 or go to the nearest Hospital Emergency Department. I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation. I understand that the COVID-19 Vaccine will be given in two separate doses.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless The Brevard Health Alliance (BHA), and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.
- I acknowledge that: (a) I understand the purposes/benefits of Florida SHOTS, Florida's immunization registry and (b) BHA will include my personal immunization information in Florida SHOTS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize BHA or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to BHA or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if BHA invoices me after the time of service, upon receipt of such invoice.
- I acknowledge receipt of the Notice of Privacy Rights.

Signature of Patient or Authorized Representative: ______________________ **Date:** __________

Print Name of Representative and Relationship to Person Receiving Vaccine: ______________________

Site (LD/RD)	Route	Manufacturer (MVX)	Lot #Unit of Use/ Unit of Sale	Expiration Date	Date of EUA Fact Sheet

Administered at Location (Facility Name/ID):	Brevard Health Alliance
Administered at Location (Type):	
Administration Address:	4315 Woodland Park Drive, Melbourne, FL 32904
CVX (Product):	
Sending Organization:	Brevard Health Alliance

Vaccinator (Print Name):		Vaccine Administering Provider Suffix:		Date:	
Signature:					