COVID-19 Vaccination Consent Under Emergency Use Authorization

## PATIENT DEMOGRAPHIC INFORMATION

| | | | |
|---|---|---|---|
| *Last Name: | *First Name: | Middle Initial: | Are you a CMH employee?: No ☐ Yes ☐ |
| *Date of Birth / / | *Sex: Male ☐ Female ☐ Transgendered ☐ Other ☐ | | |
| *Race White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan Native ☐ Hispanic Ethnicity: Yes ☐ No ☐ Unknown ☐ Refused ☐ | | | |
| Address: | | City: | |
| State: Zip: | Home Phone: | Cell Phone: | |
| Email: | Prescription Insurance ID#:_____, BIN#:_____, PCN:_____ | | |

## HEALTH HISTORY

| | | YES | NO | UNKNOWN |
|---|---|---|---|---|
| 1. | Are you moderately or severely ill today? *(Mild illnesses or taking antibiotics are not reasons to withholding vaccination.)* | ☐ | ☐ | ☐ |
| 2. | Do you have any allergies to foods or medications? If yes, please list: _____ | ☐ | ☐ | ☐ |
| 3. | Have you ever had a serious reaction after a vaccination? | ☐ | ☐ | ☐ |
| 4. | In the past 14 days have you: | | | |
| | Received any vaccines (flu, pneumonia, shingles, etc?) | ☐ | ☐ | ☐ |
| | Tested positive for COVID-19? | ☐ | ☐ | ☐ |
| | Had contact with another person with lab confirmed COVID-19? | ☐ | ☐ | ☐ |
| | _____/_____ | | | |
| 5. | In the past year, have you been diagnosed with COVID-19 by a medical provider? If yes, date of diagnosis: _____/ | ☐ | ☐ | ☐ |
| 6. | Are you breastfeeding, pregnant or planning on becoming pregnant in the next six months? | ☐ | ☐ | ☐ |
| 7. | In the past 3 months, have you taken medications that affect your immune system? *(Such as prednisone, other steroids, anticancer drugs, drugs for treatment of rheumatoid arthritis, Crohn's disease or psoriasis; or have you had radiation treatments?)* | ☐ | ☐ | ☐ |
| 8. | Do you currently have or a history of neurological condition, seizure or have ever had Guillain-Barré syndrome? | ☐ | ☐ | ☐ |
| 9. | In the past year, have you received a dose of COVID-19 vaccine? If yes, date of dose: _____, Manufacturer: _____ | ☐ | ☐ | ☐ |
| 10. | Have you received a monoclonal antibody (Bamlanivimab) or convalescent plasma to treat COVID-19 in the last 90 days? | ☐ | ☐ | ☐ |

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICP to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The CICP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use of covered countermeasures identified in a PREP Act declaration. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV–2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any such product. Information about the CICP and filing a claim is available by calling 1-855-266-2427 or visiting http://www.hrsa.gov/cicp/.

PLEASE PRINT NAME OF SIGNATURE BELOW. (Note: If patient is under the age of 18, please include signature of parent or guardian.)

| | |
|---|---|
| SIGNATURE OF PATIENT/RESIDENT | TODAY'S DATE |
| SIGNATURE OF PARENT OR GUARDIAN | TODAY'S DATE |

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, acknowledge and agree that I have received or have been advised of the Missouri Department of Health and Senior Services' Notice of Privacy Practices and where I can obtain any revisions made to this notice.

**PRINT NAME HERE**

| Signature/Legal Representative | Relationship to Patient/Resident | Today's Date |
|---|---|---|
| | | |

**FOR CLINIC USE ONLY**

| | | |
|---|---|---|
| Manufacturer: | Brand | Lot number |
| Dose number 1☐ or 2☐ or 3☐ or B☐ | *Exp. Date: _____/_____/_____ | *Date Administered: _____/_____/_____ |
| *EUA fact sheet date: ___/___/____ | * EUA fact sheet given date: _____/___/____ | Injection Site (Deltoid) L ☐ R ☐ |
| *Administered by Name & Title: | | *Facility |