COVID-19 Vaccine Registration, Screening, Acknowledgement and Consent

First Name_____ Last Name _____

Date of Birth _____ County_____

Street Address _____

City _____ State _____ Zip Code_____

Email _____ Phone _____

Race:
☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Ethnicity

Are you a member of a federal or state recognized tribal nation? ☐ Yes ☐ No

Gender: ☐ Male ☐ Female ☐ Other

How MANY conditions known to increase risk of severe illness from COVID-19 do you have?
(Cancer, Chronic Kidney Disease, COPD (Chronic Obstructive Pulmonary Disease), Down Syndrome, Heart conditions, Immunocompromised state, Obesity BMI > 30, Pregnancy, Sickle Cell Disease, Smoking, Diabetes)
☐ None ☐ One ☐ Two or more

☐ **I certify that I am:** (a) at least 18 years of age (for the Moderna vaccine); (b) at least 16 years of age (for the Pfizer vaccine); (c) the parent or legal guardian of the minor patient; or (d) the legal guardian of the patient. Further, I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an "applicable Provider"), to share my personal, demographic and health condition information (as detailed above) in order to provide me with vaccination services for the COVID-19 vaccine. I understand that the health information shared within this questionnaire will be used to determine my eligibility for receiving the COVID-19 vaccination.

SCREENING QUESTIONS

Are you currently in isolation for a recent COVID infection? ☐ Yes ☐ No
If yes, you cannot receive vaccine while you are under isolation.
Please re-schedule after you are off isolation.

Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea, or are you otherwise not feeling well? ☐ Yes ☐ No
If yes, you have symptoms that could be consistent with COVID-19.
Please obtain testing before receiving your vaccination.

Do you have a history of reactions such an immediate rash or anaphylaxis to any mRNA vaccine components? ☐ Yes ☐ No
If yes, you should not receive this vaccination. People with any prior allergic reactions to vaccine ingredients likely have increased risk of severe allergic reactions. Please consider discussing with your primary care physician or allergist prior to vaccination.

Have you received another vaccine within the last two weeks? If yes, it is not recommended that you receive vaccination. Please schedule after that time period. ☐ Yes ☐ No

Please sign Acknowledgement & Consent on back →

ACKNOWLEDGEMENT AND CONSENT

I understand that the COVID-19 vaccine has been authorized for administration by the U.S. Food and Drug Administration under an Emergency Use Authorization ("EUA"). This product has not been approved or licensed by the FDA, but has been authorized for emergency use by the FDA under an EUA to prevent COVID-19 for use in individuals 16 years of age or older (Pfizer vaccine) or 18 years of age or older (Moderna vaccine). This vaccine may not protect all vaccine recipients. I have been provided with the FDA's required EUA Patient Fact Sheet outlining the significant known and potential side effects and benefits of the COVID-19 vaccine. I understand that given its development process, all potential side effects of the vaccine may not be known at this time, and that there is currently no approved alternative to prevent COVID-19.

I further understand that:

- the full Pfizer vaccine course consists of two separate injections, 21 days apart.
- the full Moderna vaccine course consists of two separate injections, 28 days apart.
- as part of the vaccination process I will be required to remain in the vaccine administration area for up to 30 minutes following administration so that I may be monitored for any potential adverse reactions.

Life threatening allergic reactions to vaccines are very rare. Signs of a serious allergic reaction include shortness of breath, hoarseness, wheezing, hives, paleness, weakness, elevated heart rate and severe dizziness. These symptoms may occur within a few minutes, or up to 48 hours after the vaccination. If you are to experience any of these symptoms, you contact a healthcare provider immediately. Additionally, I authorize Wake County personnel to implement the necessary medical interventions should I experience an adverse reaction.

I authorize Wake County to disclose information regarding my vaccination status to my Primary Care Provider and to State vaccine registries or as otherwise permitted or required by law, consistent with the Wake County Notice of Privacy Practices. I give permission for Wake County to document the administration of the vaccine in my medical record. I acknowledge the HIPAA privacy practices and have been offered a copy.

I understand the information provided and have the opportunity to ask questions and receive answers to my satisfaction before receiving the vaccine. I further understand and acknowledge that receipt of the COVID-19 vaccine is fully voluntary, and by my signature below I acknowledge the risks and benefits of COVID-19 immunization and agree to receive the vaccine.

Signature_____ Date_____

FOR VACCINATOR USE ONLY

Vaccination Location: ☐ R Deltoid ☐ L Deltoid

Vaccination Date _____

Time _____

Administered by:

Print Name _____

Signature_____

Pfizer-BioNTech COVID-19 Vaccine

☐ Dose 1

☐ Dose 2

Moderna COVID-19 Vaccine

☐ Dose 1

☐ Dose 2