GREATER LAWRENCE FAMILY HEALTH CENTER
COVID Vaccine Consent and Screening Form

GLFHC Patient? ☐ YES ☐ NO

SECTION 1: INFORMATION ABOUT THE INDIVIDUAL TO RECEIVE VACCINE (PLEASE TYPE OR PRINT)

NAME: _____ **DATE OF BIRTH:** _____ **SEX:** _____

STREET ADDRESS (HOME): _____ **CHECK BOX IF HOMELESS:** ☐ **DO YOU RESIDE IN PUBLIC HOUSING?** ☐

CITY: _____ **STATE:** _____ **ZIP:** _____ **PHONE:** _____

ETHNICITY: ☐ **Hispanic/Spanish/Latino** ☐ **Not Hispanic/Spanish/Latino**

RACE: ☐ **WHITE** ☐ **AFRICAN AMERICAN** ☐ **ALASKA/NATIVE ASIAN** ☐ **AMERICAN INDIAN** ☐ **OTHER**

PRIMARY LANGUAGE: _____ **ARE YOU A MIGRANT OR SEASONAL WORKER:** ☐ **YES** ☐ **NO**

SECTION 2: SCREENING FOR COVID-19 VACCINE PRECAUTIONS

	YES	NO
Have you received any other vaccines within the last 14 days?	☐	☐
For those who are getting their second vaccine does, did you have a severe allergic reaction to the first COVID-19 vaccine?	☐	☐
Which vaccine product did you receive? _____		
Are you feeling sick today or do you have a recent known exposure to COVID-19 or have experienced any COVID-19 symptoms in the past 14 days?	☐	☐
Have you ever had a severe allergic reaction to any vaccine, medication or other exposure?	☐	☐
Are you pregnant or breastfeeding?	☐	☐
Are you immunocompromised?	☐	☐
Do you have dermal fillers?	☐	☐

SECTION 3: CONSENT

CONSENT FOR VACCINATION: I have read or had explained to me the Emergency Use Authorization sheet for the COVID-19 vaccine and understand the risks and benefits. In receiving this vaccination, I understand that I may experience symptoms of headache, body aches, general malaise and possible fever. This does not indicate a COVID-19 infection or adverse reaction to the vaccine, but rather my body's immune response to the vaccine. **I GIVE CONSENT or have the LEGAL AUTHORITY** to consent on behalf of said individual to receive the COVID-19 vaccine and understand that two doses of the vaccine (21-28 days apart) are needed. I also understand that this vaccine is being administered under the Emergency Use Authorization (EUA) and has not yet received full FDA approval. I will notify my PCP should I experience a severe reaction. I give permission for my insurance company to be billed for the costs of administering the vaccine.

_____ _____

Signature of Individual Receiving a Vaccine or Parent/Authorized Guardian — Date

SECTION 4: HEALTH INSURANCE INFORMATION

INSURANCE ID/GROUP #: _____ INSURANCE COMPANY: _____

RX BIN: _____ MEDICARE PART B (if applicable) _____

POLICY HOLDER NAME: _____ RELATIONSHIP TO INDIVIDUAL: _____

SECTION 5: VACCINE ADMINISTRATION DOCUMENTATION

MANUFACTURER: _____ **LOT #:** _____ **EXPIRATION DATE:** _____

ADMINISTRATION DATE _____ **SITE:** ☐ R DELTOID ☐ L DELTOID **DOSE:** ☐ 1ST DOSE ☐ 2ND DOSE

ADMINISTERING CLINICIAN: _____ **REACTION NOTED** ☐ **YES** ☐ **NO**

NEXT APPOIINTMENT? _____

Greater Lawrence Family Health Center

CONSENT FOR MINOR'S VACCINATION:

I agree that:

1. I have the legal authority to consent to have the child _____ vaccinated with the Pfizer-BioNTech COVID-19 Vaccine.

2. I understand I am not required to accompany the child named above to their vaccination appointment and that, by giving my consent below, the child will receive the Pfizer-BioNTech COVID-19 Vaccine whether or not I am present at the vaccination appointment.

3. If I am not accompanying the child named above to their vaccination appointment, I will provide a completed pre vaccination screening form, available at: https://glfhc.org/covid-19-vaccine-signup-form/

4. If I have health insurance that covers the child named above, I give permission for my insurance company to be billed for the costs of administering the Pfizer- BioNTech COVID-19 Vaccine. The government is paying for the Pfizer-BioNTech COVID-19 Vaccine itself, and I will not be billed for that portion of the cost of my immunization.

5. I understand that as required by state law, all immunizations will be reported to the Department of Public Health Massachusetts Immunization Information System (MIIS). I can access the MIIS Fact Sheet for Parents and Patients, at www.mass.gov/dph/miis, for information on the MIIS and what to do if I object to my or my family's data being shared with other providers in the MIIS.

I GIVE CONSENT for the child named at the top of this form to get vaccinated with the Pfizer-BioNTech COVID-19 Vaccine and have reviewed and agree to the information above (If this consent is not signed, dated and returned, the child will not be vaccinated.)

_____ _____

Signature of Legally Authorized Representative Date