ARKANSAS DEPARTMENT of HEALTH (ADH) COVID-19 IMMUNIZATION CONSENT FORM

For COVID-19 Provider use only Clinic Name/Code: _____
Location type:(clinic, health department, pharmacy, etc.,) _____
Address: _____City:_____ County: _____
State:_____ Zip Code: _____ Date of Service:_____

Person Receiving Vaccine:

(Legal) First Name: _____ MI: ____ Last Name: _____

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐

1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. If you answer "YES" you may not be able to receive the COVID-19 vaccine.

ADH staff: *If YES and further guidance is needed, notify your local Communicable Disease Nurse Specialist (CDNS) or the Arkansas Department of Health, Immunization Section @ 501-537-8969. Refer to Pre-vaccination Checklist for COVID-19 Vaccines Information for Healthcare Professionals (cdc.gov) to clarify further questions:www.cdc.gov/vaccines/covid-19/downloads/pre-vaccination-screening-form.pdf.	*YES	NO
Have you had a previous COVID-19 vaccine? If yes, what type and date?		
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?		
Have you ever had an allergic reaction to a COVID-19 vaccine, or a COVID-19 vaccine component (including polyethylene glycol [PEG], which is found in some medications, or laxatives, and preparations for colonoscopy; or polysorbate which is found in some vaccines, coated tablets, or IV steroids)?		
Have you ever had an immediate allergic reaction of any severity to any vaccine or injectable therapy? This includes an anaphylactic reaction that required treatment with epinephrine (or EpiPen) or treatment at a hospital, or an allergic reaction that occurred within 4 hours, such as difficulty breathing, hives, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness, and weakness.		
Do you have a bleeding disorder or are you taking a blood thinner?		
Did you develop myocarditis or pericarditis after the first dose of COVID-19 vaccine? Do you have history of myocarditis or pericarditis prior to COVID-19 vaccination? Are you a male between age 12 through 29 years?		
Have you ever had a severe allergic reaction (anaphylaxis) to something other than a component of COVID-19 vaccine or any vaccine or injectable medication such as food, pet, venom, environmental, or oral medication allergies?		
Are you pregnant, breastfeeding, planning to become pregnant? Women in this group may receive any FDA-authorized COVID-19 vaccine. Women 18 through 49 years of age can receive any FDA-authorized COVID-19 vaccine and should be informed of the increased risk of thrombosis with thrombocytopenia syndrome (TTS) after receiving Janssen COVID-19 Vaccine and the availability of other (mRNA)COVID-19 vaccines.		
Are you immunocompromised? Do you have a condition that weakens your immune system? Are you receiving any immunosuppressive therapy? You are still eligible to receive any FDA-authorized COVID-19 vaccine unless you have a contraindication for some other reason. However, you will need special counseling about the vaccine.		
Have you had history of heparin-induced thrombocytopenia? If it has been 90 days or less since illness resolved, you may receive Pfizer-BioNTech or Moderna COVID-19 vaccine. After 90 days since illness resolved, you may be vaccinated with any FDA-authorized COVID-19 vaccine.		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Have you had Multisystem Inflammatory Syndrome (MIS)? Pfizer-BioNTech, Moderna, or Janssen COVID-19 vaccination should be deferred for at least 90 days to avoid interference with vaccine-induced immune responses.		

NOTE: Recipients of Janssen COVID-19 vaccine should be instructed to seek immediate medical attention if they develop shortness of breath, chest pain, leg pain or swelling, persistent abdominal pain, neurological symptoms (including severe or persistent headaches or blurred vision), nausea, vomiting, petechiae, or easy bleeding beyond the site of vaccination within 4 to 30 days of receipt of Janssen vaccine. Most people who have developed blood clots and low platelets were females ages 18 through 49 years.

NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine **may** be due in 21 days or 28 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your vaccination provider, PCP, or your ADH Local Health Unit in 21 days or 28 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. Janssen COVID-19 vaccine is a ONE dose series.

2. **RELEASE AND ASSIGNMENT:**
Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form.
Then sign in the box at right. **Please sign here**

My signature below indicates I have read, understand, and agree to section **2. Release and Assignment** of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).
Signature of Patient/Parent/Guardian:

_____Date_____

RELEASE AND ASSIGNMENT:

- I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient EUA Fact Sheet for Pfizer COVID-19 vaccine, Moderna COVID-19 vaccine, or Janssen COVID-19 vaccine visit https://www.cdc.gov/vaccines/covid-19/eua/index.html or you may also visit your Local Health Unit or PCP to receive a printed copy of the EUA Fact Sheet.
- I give consent to this COVID-19 provider/staff for the individual named below to be vaccinated with COVID-19 vaccine.
- I hereby acknowledge that I have reviewed a copy of the Provider's Privacy Notice.
- I understand that information about this COVID-19 vaccination will be included in (WebIZ) Arkansas Immunization Information System.

To My Insurance Carrier(s):

- I authorize the release of any medical information necessary to process my insurance claim(s).
- I authorize and request payment of medical benefits directly to this COVID-19 Provider.
- I agree that the authorization will cover all medical services rendered until I revoke the authorization.
- I agree that the photocopy of this form may be used instead of the original.

PATIENT INFORMATION:

(Legal) First Name: _____ **MI:** ____ **Last Name:** _____

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ **Gender:** ☐ Male ☐ Female **Phone #:** _____

Street Address: _____ **P.O. Box** _____ **Apt. No.** _____

City: _____ **State:** _____ **Zip Code:** ☐☐☐☐☐

Race: ☐ Asian ☐ Black/African American ☐ Native American /Alaska Native ☐ Native-Hawaiian/Other Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

INSURANCE STATUS (Check appropriate box):

Patient's Relationship to Insurance Policy Holder: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

☐ **Medicaid/ARKids Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐ **Medicare Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐ **Insurance Company Name**: _____

Member ID/Policy #: ☐☐☐☐☐☐☐☐☐☐☐☐☐

REQUIRED POLICY HOLDER INFORMATION:

(Legal) First Name: _____ **MI:** ____ **Last Name:** _____

Policy Holder Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ **Email Address:** _____

Policy Holder's Employer Name: _____

COVID-19 VACCINE ADMINISTRATION (Completed by staff only)

Co-administration of COVID-19 vaccines and other vaccines. COVID-19 vaccines and other vaccines **may be administered without regard to timing.** This includes simultaneous administration of COVID-19 vaccines and other vaccines during the same visit. Other vaccines can also be administered any time before or after COVID-19 vaccination.

Ultra-cold COVID-19 Vaccine ☐ Pfizer-BioNTech		**Frozen COVID-19 Vaccine** ☐ Moderna		**Refrigerated COVID-19 Vaccine** ☐ AstraZeneca ☐ Janssen (Johnson & Johnson) ☐ Novavax-Matrix-M1 ☐ Other COVID-19 Vaccine _____
Route	**Site Code**	**Dosage mL**	**MFG Code**	**Lot Number**
☐ **IM**				

MFG Codes: PFR=Pfizer-BioNTech, MOD=Moderna, ASZ=AstraZeneca, JSN=Janssen, NVX=Novavax, MSD=Merck

Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA

Signature and Title of Vaccine Administrator: _____

Date Vaccine Administered: _____/_____/_____

FORM 4133 Revised 8/5/2021