AACI COVID-19 Vaccination – 2. Screening & Consent Form

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: M / F

Instructions: Please answer the following questions to the best of your knowledge. The questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "yes" to any question, we may ask you to talk to your primary care provider *first* before getting the vaccine. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID – 19 vaccine?			
• If yes, which vaccine product? ○ Pfizer (available to youth ages 12-17) ○ Moderna ○ Janssen ○ Other			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example a reaction for which you were treated with epinephrine or Epipen, or for which you had to go to the hospital?			
• Was the severe allergic reaction after receiving a COVID -19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine, or another injectable medication?			
4. Have you ever received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID – 19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID – 19 or has a doctor ever told you that you had COVID – 19?			
7. Do you have a weakened immune system caused by something such as a HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			

Turn over and please read and sign the consent

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By signing this form, you confirm that you understand and agree to the following:

- You have answered all of the screening questions to be best of your knowledge. If you answered yes to any of the questions, you have conferred with your healthcare provider about receiving the COVID vaccine.
- You are not creating a patient-provider relationship with AACI Health Center by consenting to and receiving the Vaccine.
- AACI Health Center will not act as your healthcare provider unless you are already an established primary care patient of AACI Health Center.
- In the event you experience any side effects, you will seek appropriate consultation and treatment from your primary healthcare provider.
- You have been informed of the nature of the Vaccine, its intended benefits, and its potential risks.
- You have been given the opportunity to ask questions before signing this consent, and you have been told that you can ask other questions at any time.
- All of your questions (if any) have been answered to your satisfaction.
- You have the right to receive a copy of this consent form.
- You understand that AACI Health Center is required by law to register your receipt of the Vaccine in the VAMS system.
- You voluntarily consent to AACI Health Center registering your receipt of the Vaccine in the VAMS system.
- You understand that AACI Health Center may be obligated to report additional information regarding you and your receipt of the Vaccine to federal, state, and local government agencies.
- You voluntarily agree to receive the Vaccine.

I have received and read the Information provided to me on the Emergency Use Authorization (EUA) statement from the FDA about the COVID-19 vaccine I am about to receive. I consent to administration of this vaccine.

Print Name: _____

Signature: _____ Date: _____