FALLS COMMUNITY HOSPITAL
&CLINIC COVID19 CONSENT FORM

PATIENT'S INFORMATION (PLEASE CLEARLY PRINT)

Last Name:	First Name:	Middle Name:

Address:	City:	State:	Zip Code:	County

Date of Birth: ____/____/_____(Month/Day/Year)	Sex: M / F	Race:	Age:	Phone	Email:

Do you have insurance? ☐Yes ☐No	Subscriber/ Member ID	Subscriber Date of Birth	Insurance Company:

If no insurance, provide the following: Driver License #	State of Issue

Emergency Contact Name	Emergency Contact Phone

COVID-19 VACCINATION INFORMATION

The _☐Pfizer ☐Moderna_ COVID-19 vaccine has been authorized by the Food and Drug Administration under an Emergency Use Authorization, or EUA, based on advice from the Secretary of Health and Human Services in response to the ongoing COVID-19 Pandemic. The COVID-19 vaccine has not been fully approved but is being made available under an EUA due to scientific evidence supporting the safety and efficacy of the COVID-19 vaccine and the vaccine's highly favorable risk-benefit ratio.

Falls Community Hospital & Clinic is authorized to administer the _☐Pfizer ☐Moderna_ COVID-19 Vaccine based on guidance developed by Centers for Disease Control and Prevention. In order to optimize vaccine response, you will receive 2 doses separated by _☐21 ☐28_ days. Side effects reported in clinical trial of this vaccine include, but may not be limited to, injection site pain, redness, or swelling, fatigue, headache, muscle pain, chills, fever, joint pain, nausea, or lymph node swelling. Such symptoms normally resolve within 24 hours and are typically mild but if severe should be reported to _____.

If severe allergic symptoms develop (trouble breathing, chest pain, fast heartbeat dizziness, weakness, facial, tongue, or throat swelling, or rash) after your observation period is complete, please call 911 or proceed to the nearest Hospital Emergency Department.

SCREENING CHECKLIST FOR TODAY'S IMMUNIZATION

1	Are you sick today?	Yes	No
2	Have you received any vaccinations in the last 14 days, or have you received any other COVID-19 vaccine previously?	Yes	No
3	Have you been diagnosed with COVID-19 infection within the last 90 days?	Yes	No
4	Have you ever had a reaction to any COVID-19 vaccine components (mRNA, several different lipid ingredients)?	Yes	No

If you answered "Yes" to questions 1-4, we would advise you to postpone vaccination for COVID-19 as follows:

- If sick, wait until your symptoms have resolved. If you are COVID+, wait until 90 days have elapsed since positive COVID-19 test.
- Wait 2 weeks after other vaccinations to receive COVID-19 vaccination.
- You should not take the ☐Pfizer ☐Moderna COVID-19 vaccine if your first COVID-19 vaccine was produced by another manufacturer.
- If you have a history of anaphylaxis to any ingredient of the ☐Pfizer ☐Moderna vaccine, you CANNOT receive this vaccine based on current guidance.

5	Have you ever had a severe allergic reaction (anaphylactic) to a vaccine (including trouble breathing, hives, facial or tongue swelling, low blood pressure, fast heart rate) or other severe reaction to a vaccination?	Yes	No
6	Do you have a history of severe allergic reaction to anything besides a vaccine, including other medications, insect stings, or bites?	Yes	No
7	Do you take blood thinner or do you have a bleeding disorder?	Yes	No

If your answer to any of questions 5, 6, or 7 is "Yes", please notify the staff so that we can make the accommodations necessary to observe you more carefully following your vaccination., and if you have a bleeding tendency or are on blood thinners, we will watch you carefully for possible injection site bleeding.

8	Do you a weakened immune system?	Yes	No
9	Are you now pregnant or might you become pregnant in the next 4 weeks, or are you breastfeeding?	Yes	No

If you answered "Yes" to questions 8 or 9, you can choose to be vaccinated but safety and efficacy data is still being collected for people in these groups.

10	Have you had COVID 19 in the last 90 days?	Yes	No

CONSENT FOR VACCINATION AND BILLING INSURANCE

I have been provided with and have read the EUA Fact Sheet for the COVID-19 vaccine, the COVID-19 Vaccine Consent Form, and any additional information provided. I have had the opportunity for my questions to be answered by a medical professional, and I understand that a series of two vaccines will be required. I understand the known risks and benefits of vaccination and understand that not all risks may have yet been established. I know that I am consenting to this vaccine series under an EUA in response to the COVID-19 Pandemic. I request to proceed with vaccination.

I understand FCHC will use the information gathered to submit a claim to your insurance company for only the administration of the vaccine. I agree to remain on site for 15 minutes after vaccination and that my condition may warrant post vaccination observation for at least 30 minutes.

Date:	**Time:**	**Relationship to Patient:**
Print Name		**Signature**
Administered by		**Date**

Vaccine	Vaccine Info	Site	Manufacturer	Lot #	Expiration Date
COVID-19 Vaccine	**Series** ☐1st ☐2nd	Deltoid: ☐Left ☐Right	☐Pfizer ☐Moderna ☐_____		

Date of Administration	**Vaccine Administrator Signature/Title or Credentials**	**Location**

SCAN TO PATIENT CHART