Old Dominion University Informed Consent for Immunization with COVID-19 Vaccine

									<u> ⊔M</u>
Last Name		First Name	I	Middle	Da	te of Birth	Age		Gender
Uana Addusas		Cit.	Chaha		7:	()		
Home Address		City	State	1	Zip	Pnon	e # □Home	□Cell	
	☐ Black or African Ar ispanic or Latino ☐No	•			Pacific Island	der □Two or Mo	ore □ Other:		
Which arm do (Please circle)	you prefer for vaccine? Left Right	Enter weight IF LES	S than 66 pounds: _	Lb		ry Care Provider I ry Care Provider A			
Screening Qu	estionnaire: Please ans	wer questions by checki	ng the boxes.						
Screening Que	stions – NOTE: IF COM	PLETED ONLINE, REVIE	W ANSWERS WITH P	ATIENT TO E	NSURE NO	CHANGES		Yes	No
1. Are yo	u sick today?								
All the second of the second o									
2 I '	Have you ever had an allergic reaction to a previous COVID-19 vaccine or any component of the COVID-19 vaccine, including polyethylene glycol (PEG) or polysorbate?						cluding		0
	ou ever had an allergic			•					
5. Have you ever had a severe allergic reaction (anaphylaxis) to any food, pet, environmental allergens, oral medications, or latex? If yes, please list:									
6. Have y	Have you received any vaccines in the past 14 days? (not a contraindication)								
7. '	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19 within the last 90 days?							О	
8. Are yo	u pregnant or breastfee	eding? (not a contraindi	cation)						
acknowledge the Information State Questions have Privacy Practices Privacy Practices Protections und	y of anaphylaxis due to a at I am doing so at my ov tement(s) ("VIS") or Eme been answered to my sats in compliance with the er state or federal law, is ny primary care physician	vn risk and against the ac rgency Use Authorizatior isfaction. I understand tl Health Insurance Portab subject to reporting by	dvice of the profession ("EUA") provided for the benefits and risks of lility and Accountabilit my pharmacy or its bu	nal who admin r the vaccine(s of the vaccine sy Act (HIPAA) usiness associa	nistered the v s) to be admi (s). 6) I have I . 7) This vacci ate to an imm	vaccine. 5) I have r nistered. I have ha peen offered and/ nation, including a nunization registry	ead, or have h d the opportu or provided a iny vaccinatior , which may sl	ad read nity to a copy of t n granted nare my	to me, the Vaccine sk questions, and all my he company's Notice o I additional privacy
Signature of Patient or Parent/Guardian of Minor Patient Date									
			For Dispe	nsary Use Or	nly		1		1
Vaccine Na	me Lot#	Expiration Date	Manufacturer	Dose (ml)	Dose #	Route	Site (cir	cle)	VIS/EUA Publication Date
							R / L L	Deltoid	
Name of Admi	nistrator:	Administr	Administration Date:						Accepted / Declined
_	[Indicates (1) VIS/EUA F	-							
WA ONLY: Sub	stitution Permitted:			_ Dispense	as Written:				
RxBIN:		PCN:	_ Group#:			_ ID#:			
Medical (Name	, ID#, Group#, Payer ID	- if UHC):							
Billing Info (off-	site only) Clinic Name:		Clinic Addres	s:					