



INDEPENDENCE

* MISSOURI *

COVID-19 Vaccination Consent under Emergency Use Authorization

PATIENT DEMOGRAPHIC INFORMATION

*Last Name:	*First Name:	Middle Initial:
*Date of Birth / /	*Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Transgendered <input type="checkbox"/> Other <input type="checkbox"/>	
*Race White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/>	Hispanic Ethnicity: Yes <input type="checkbox"/> No <input type="checkbox"/>	
American Indian/Alaskan Native <input type="checkbox"/> None Specified <input type="checkbox"/> Refused <input type="checkbox"/>	Unknown <input type="checkbox"/> Refused <input type="checkbox"/>	
Address:		City:
State: Zip:	Home Phone:	Cell Phone:
Email:	Would like a reminder for the next appointment Yes <input type="checkbox"/> or No <input type="checkbox"/> postcard/call/text	

HEALTH HISTORY

	<u>YES</u>	<u>NO</u>	<u>UNKNOWN</u>
1. Are you feeling sick today ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. 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 Epi Pen or for which you had to go to the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after any vaccination or injectable medication including a previous dose of the COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. In the past 14 days have you had contact with a confirmed COVID-19 patient ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you breastfeeding or pregnant ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you received passive antibody therapy as a treatment for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you immunocompromised ? (<i>taking medication or being treated for cancer, leukemia, HIV/AIDS or other immune system problems or taking medication that affects your immune system</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have a bleeding disorder or are you taking a blood thinner ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever received a dose of COVID-19 vaccine ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

***N.B.: Please be sure to fill and sign the Acknowledgement of Notice of Privacy Practices on the following page**



INDEPENDENCE

★ MISSOURI ★

COVID-19 Vaccination Consent under Emergency Use Authorization

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICP to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The CICP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use of covered countermeasures identified in a PREP Act declaration. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV-2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any such product. Information about the CICP and filing a claim is available by calling 1-855-266-2427 or visiting <https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine>

PLEASE PRINT NAME of signature below

SIGNATURE OF PATIENT	RELATIONSHIP TO CLIENT	TODAY'S DATE
----------------------	------------------------	--------------

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge and agree that I have received or have been advised of the Missouri Department of Health and Senior Services' Notice of Privacy Practices and where I can obtain any revisions made to this Notice.
Print Name Here

<i>Client Signature/Legal Representative</i>	<i>Relationship to Client</i>	<i>Today's Date</i>
--	-------------------------------	---------------------

For Clinic Use only

Manufacturer	Brand	Lot number
Dose number 1 <input type="checkbox"/> or 2 <input type="checkbox"/>	*Exp. Date: ___/___/___	*Date Administered: ___/___/___
*EUA fact sheet date: ___/___/___	*EUA fact sheet given date: ___/___/___	Injection Site (Deltoid) L <input type="checkbox"/> R <input type="checkbox"/>
		Vaccine Dose _____
*Administered by Name & Title :		
*Agency:		
*Agency Address		
*Clinic administration address		