COVID-19 Vaccination Consent under Emergency Use Authorization

PATIENT DEMOGRAPHIC INFORMATION - PLEASE PRINT CLEARLY

*Last Name: | *First Name: | Middle Initial:

*Date of Birth / / | Age: | *Sex: Male ☐ Female ☐ Transgendered ☐ Other ☐

*Race White ☐ Black ☐ Asian ☐ Pacific Islander ☐ | Hispanic Ethnicity: Yes ☐ No ☐

American Indian/Alaskan Native ☐ None Specified ☐ Refused ☐ | Unknown ☐ Refused ☐

Address: | City:

State: Zip: | Home Phone: | Cell Phone:

County: | Email Address:

The State of Missouri is conducting a phased roll-out of the COVID-19 vaccine prioritizing saving lives and is dictated by vaccine availability. This form will gather information about you, including your employment and health risks to determine your eligibility and properly schedule your vaccination appointment. All your information will be kept confidential to the extent allowed by law. By signing this form you are self-certifying that everything you have indicated on this form is true and that you fall into the phase/tier indicated below.

EMPLOYER: | OCCUPATION:

Phase 1B - Tier 1 Worker Information: Protecting those who keep us safe and help during emergencies

☐ First Responders ☐ Non-Patient Facing Public Health Infrastructure ☐ Emergency Management and Public Works
☐ Emergency Services Sector

Phase 1B - Tier 2 High-Risk Individuals: Protecting those who are at increased risk for severe illness

☐ Anyone aged 65 and older
☐ Any Adult with the following conditions:
Cancer, Chronic Kidney Disease, COPD (chronic obstructive pulmonary disease), Intellectual and/or developmental disabilities such as Down Syndrome, Heart Conditions (such as heart failure, coronary artery disease, or cardiomyopathies), Immunocompromised state from solid organ transplant, Severe Obesity (BMI greater than 40), Pregnancy, Sickle Cell Disease, &/or Type 2 Diabetes Mellitus

Phase 1B - Tier 3 Critical Infrastructure Workers: Protecting those who keep the essential functions of society running

☐ Education (K-12) ☐ Childcare ☐ Communications Sector ☐ Dams Sector ☐ Energy Sector
☐ Information Technology Sector ☐ Nuclear Reactors, Materials, and Waste Sector
☐ Transportation Systems Sector ☐ Water and Wastewater Systems Sector
☐ Government: Certain elected/appointed officials or other personnel designated by the executive, legislative, and judicial branches of state government
☐ Food/Agriculture Sector – initial: Employees of certain food production and processing facilities, and related operations, prioritizing mass food production, distribution, transportation, wholesale, veterinary serves, and retail sales.

Phase 2, Equity & Economic Recovery: Protecting those who have been disproportionately affected and accelerating economic recovery

☐ Chemical Sector ☐ Commercial Facilities Sector ☐ Critical Manufacturing Sector ☐ Defense Industrial Base Sector
☐ Financial Services Sector ☐ Higher Education ☐ Disproportionately Affected ☐ Homeless
☐ Government: Other state and local government designated personnel required to provide essential services
☐ Food/Agriculture Sector II: Remaining populations within the sector not included in 1B, including restaurants

Phase 3, Remaining Unvaccinated Populations: Protecting everyone else who has not been vaccinated, but wants to do so

☐ Resident who doesn't fall into the above phases/tiers

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

SIGNATURE REQUIRED ON BACK >>>

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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

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. >>> Please Initial Here: X ______

ACKNOWLEDGMENT OF INSURANCE BILLING

I acknowledge that the federal government is offering the COVID-19 vaccine *free of charge* to those wishing to receive it and that Ralls County Health Department may bill my insurance for the fee associated with administration of the vaccine. >>> Please Initial Here: X ______

☐ **Private Insurance: (Please check one)**

___Anthem/BCBS ___Aetna ___Cigna ___Coventry ___Healthlink ___UHC

Member #: ______________________ Group #: ______________________

Customer Service #: ______________________

☐ **Medicaid/MO HealthNet DCN#:** ______________________

☐ **Medicare #:** ______________________

☐ **American Indian/Alaska Native**

☐ **No Insurance or Underinsured**

PLEASE PRINT NAME of signature X		
SIGNATURE OF PATIENT or Legal Representative X	RELATIONSHIP TO CLIENT (If Applicable)	TODAY'S DATE X

------------------------------------ CLINIC USE ONLY ------------------------------------

FOR NURSE USE ONLY		
Manufacturer:	Brand: COVID-19 VACCINE	Lot number:
Dose number 1☐ or 2☐	*Exp. Date:	*Date Administered:
*EUA fact sheet date:	EUA fact sheet given date:	Injection Site (Deltoid) L ☐ R ☐
___ Clinical Judgement – all vaccinators are encouraged to use their clinical judgement/discretion to authorize a vaccine for any individual, regardless of where they may otherwise fall in the prioritization process.		
*Administered by Name & Title : *NURSE SIGNATURE*: ______________________		
*Agency: Ralls County Health Dept., 405 W. First St., New London MO 63459		
*Clinic administration address: ___ Arch Methodist Church, 56017 Ocean Wave Rd., New London MO 63459 ___ ___ ______________________		