COVID-19 Vaccine
Screening and Consent Form

THE DIMOCK CENTER

Healing and caring for the community for over 150 years.

Patient Name: ____

DOB ____________________________________ Today's Date: _____________________

Please answer the following questions:

		Yes	No	Not Sure
1.	Are you feeling sick today?	☐	☐	☐
2.	Do you have any condition such as cancer or HIV/AIDS that weakens the immune system?	☐	☐	☐
3	Do you have take any medications such as prednisone, anti-cancer drugs that weaken the immune system or have you recently received radiation treatment?	☐	☐	☐
4.	Are you pregnant or breastfeeding? If yes, please consult your OBGYN.	☐	☐	☐
5	In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	☐	☐	☐
6.	Have you been treated with antibody therapy for COVID-19 in the past 90 days (3 months)? If yes, when did you receive the last dose?	☐	☐	☐
7.	Have you received any vaccinations in the past 14 days?	☐	☐	☐
8.	Do you take anticoagulation medications like Coumadin or Aspirin?	☐	☐	☐
9.	Do you have a history of severe allergic reactions to any vaccines or injectable medications?	☐	☐	☐
10.	Do you have a history of severe allergic reaction to any component of the vaccine? (Please see EUA for ingredient list)	☐	☐	☐

Emergency Use Authorization: The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

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I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

I hereby certify that the foregoing history is true and complete to the best of my knowledge and that I have had the opportunity to review the Emergency Use Authorization (EUA). I hereby consent to the administration of the COVID-19 vaccine. Furthermore, I hereby release The Dimock Center and their employees, owners, and representatives from any and all claims and demands, actions and causes of actions, which may result from participation in this program.

Patient Informed Consent Signature: ________________________________Date_________________

OR

Parent/Guardian Signature ____Date__________________

Print Name: _________________________________Relationship to Patient ______________________

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For Office Use Only

Date of Vaccination: _____________ Vaccine Product Name_______________________

Lot #_____________Expiration Date: ______ Injection Site: ☐Right Deltoid ☐Left Deltoid

Vaccine Administrator Signature: ____