Hamed Kabiri, MD, FACEP,AAEM
Georgeta Sealey, PA-C
Michael Vuong, PA-C

First Name: _____ Last Name: _____ DOB: _____

SCREENING FOR VACCINATION ELIGIBILITY		
1. Are you pregnant or breastfeeding?	Yes	No
2. Are you a minor or under the age of 16?	Yes	No
3. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any vaccine or injectable therapy?	Yes	No
4. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions of COVID-19 within the past 90 days?	Yes	No
5. Do you have a bleeding disorder or are you currently taking any blood thinners (heparin, warfarin, aspirin etc.)?	Yes	No
6. Do you have a weakened immune system caused by something such as HIV or cancer or do you take immunosuppressive drugs or therapies?	Yes	No
7. In the past 48 hours, have you experienced any symptoms related to COVID-19 such as: fever, chills, dry cough, shortness of breath, difficulty breathing, fatigue, body aches, loss of taste or smell?	Yes	No
8. In the past 14 days have you tested positive for COVID-19?	Yes	No
9. In the past 14 days, have you had known close contact* with a person who has confirmed COVID-19? *** "Close contact" is defined as: household member, intimate partner, caregiver or having a face-to-face conversation for 10 minutes or more within a distance of less than 6 feet.**	Yes	No
10. Have you received your first dose of the COVID-19 vaccine or if this is your second dose, when was the date of your first dose? _____ (Pfizer or Moderna)?	Yes	No

ADVERSE REACTIONS

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of any vaccine causing serious harm, or death, is extremely small. Local symptoms may include: pain, redness, itching or swelling at the site of injection. Systemic symptoms may include: fever, malaise, headache, nausea, chills, and muscle pain. These reactions usually begin 6 to 12 hours after immunization and can persist for a few days. Allergic reactions are common immune responses and may result from hypersensitive reactions in people with severe egg allergy, and such people should not be given certain vaccines that contain eggs. People with documented immunoglobulin E (IgE)-mediated hypersensitivities to eggs or any other vaccine components, including thimerosal, may also be at increased risk of reactions from immunizations. Many allergic reactions are mild, while others can be severe or even life threatening. The most severe form of an allergic reaction is called anaphylaxis which occurs suddenly or within minutes of exposure. Anaphylaxis requires immediate medical attention and without the proper treatment can result in death. Common signs of an allergic reaction can include: difficulty breathing, wheezing (respiratory distress), hives, paleness, weakness, tachycardia, dizziness, or swelling may occur immediately or within four hours after vaccination.

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CONSENT FOR VACCINATION

I have read the adverse reactions associated with the administration of vaccines. The vaccine you are receiving may have been authorized by the FDA under Emergency Use Authorization (EUA). Vaccines authorized under EUA have been rigorously assessed for efficacy and safety. A copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risk and voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization(s) by the person named below for whom I am the legal guardian ('Ward'). I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives and assigns, hereby release Optimum Care and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt by my Ward of this or these immunization(s). Neither Optimum Care nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. Optimum Care will use and disclose your personal and health information or the personal and health information of your Ward, to treat you or your Ward, to receive payment of the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to you and your Ward's personal health information. I acknowledge that I have received a copy of the Notice of Privacy Practice. I will/ have reviewed my answers to the questions above with the vaccinator. If I experience any adverse after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization Fact Sheet provided to me today. I understand the benefits and risks of the vaccine.The vaccine checked above should be given to the person named above for whom I am authorized to make this request. I understand that I can review a Notice of Privacy Practice at the time of vaccination.

By signing this form I consent that I have received and reviewed the COVID-19 fact sheet. I consent to waiting the observation time of 15 to 30 minutes after administration of the COVID-19 vaccine.

_____

Signature of Patient/ Parent/Guardian Date

FOR ADMINISTRATIVE USE ONLY

Vaccine Manufacturer: _____ Date : _____ Time:_____

Lot #: _____ Exp Date: _____ Route: IM R L

Printed Name and Signature of Vaccine Administrator: _____