COMMUNITY HEALTH ALLIANCE

Vaccine Informed Consent (COVID Booster)

Patient Information

First Name: _____ Last Name: _____ Date of Birth: _____ Age: ____

Address: _____ Phone: _____

_____

Insurance Information

Insurance Name: _____ BIN Number: _____

ID Number: _____ Group Number: _____

Medicare or Uninsured:

SSN: _____

Initial Series Information

Circle one: I originally received: Pfizer Moderna Johnson/Johnson

Date of DOSE 1: ___/___/___
Date of DOSE 2: ___/___/___
Date of DOSE 3: ___/___/___

Check one: Are you here to receive a booster of : ☐ **Pfizer** ☐ **Moderna** ☐ **Johnson/Johnson**

Screening Questionnaire

	Yes	No
Are you sick today? If yes, list your symptoms: _____	☐	☐
Have you or anyone in your household been exposed to, diagnosed with, or has been placed in quarantine for COVID-19 in the past 14 days?	☐	☐
Have you received passive antibody therapy as treatment for COVID-19 in the past 90 days?	☐	☐
Have you ever had a severe allergic reaction (anaphylaxis) to any medications, latex, foods, pets or insects that required the use or treatment with epinephrine (EpiPen)? If yes, please list allergies: _____	☐	☐
Do you have an underlying medical condition like liver, kidney, heart disease, diabetes, or are immunocompromised?	☐	☐
Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐
For women: Are you currently pregnant?	☐	☐

I, the undersigned, hereby acknowledge that I have received the Emergency Use Authorization (EUA) vaccine sheet. I have had the opportunity to ask questions for the immunization to be administered to me or the person named above, for whom I am authorized to make this request. I agree to allow my immunization information to be stored and accessed by authorized users in Nevada's WebIZ. I voluntarily request that the vaccine be given to me or for the aforementioned person for whom I am authorized to make this request. By signing this document, I declare that the above information is true and accurate to the best of my knowledge.

☐ I authorize the vaccine to be administered by a trained student pharmacist.

Signature: _____ Date: _____

If under 18, print name of parent, guardian or caregiver: _____

Vaccine	Lot #	Exp Date	Route	Site	Dose	Date Given	Administered by:
Moderna (MOD)			IM	LD or RD	**0.25 ml**		
Pfizer (PFR)			IM	LD or RD	**0.3 ml**		
Johnson/Johnson			IM	LD or RD	**0.5 ml**		

☐ Entered into WebIZ

Please see backside

COVID Booster or Third Doses

Pfizer and Moderna Booster Shots: COVID-19 booster shots are available for the following Pfizer and Moderna recipients who completed their initial series at least 6 months ago and are:

- Age 65 and older
- Age 18 or over and resident of long-term care setting
- Age 18 or over with certain underlying medical conditions, including:
  - Cancer
  - Chronic kidney disease
  - Chronic lung disease
  - Dementia or other neurological conditions
  - Diabetes
  - Down syndrome
  - Heart conditions
  - HIV infection
  - Immunocompromised
  - Liver disease
  - Overweight and obesity
  - Pregnancy
  - Sickle cell disease or thalassemia
  - Smoking, current or former
  - Solid organ or blood stem cell transplant recipient
  - Stroke or cerebrovascular disease
  - Substance use disorder
- Age 18 or over at increased risk for COVID-19 exposure and transmission due to occupational or institutional settings

Johnson/Johnson Booster Shots: Booster shots are available to those who have received a Johnson/Johnson vaccine at least two months ago.

Third Doses: Third doses of either Pfizer or Moderna are authorized for individuals who received 2 doses of either Pfizer or Moderna and the 2nd dose was at least 28 days ago AND are considered moderately to severely immunocompromised, including:

- Been receiving active cancer treatment for tumors or cancers of the blood
- Received an organ transplant and are taking medicine to suppress the immune system
- Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system
- Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
- Advanced or untreated HIV infection
- Active treatment with high-dose corticosteroids or other drugs that may suppress your immune response

Individuals must self-attest that they meet these criteria to be eligible for a COVID vaccine booster or third dose.

Patient Name: _____ Date of Birth: _____

Prior Vaccine Received: _____ Date of Last Dose: _____

Check the box applicable to you:

☐ **Yes, I meet the criteria listed above.**

☐ **No, I do not meet the criteria listed above.**

Signature: _____ Date: _____