Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Name _____

Age _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• Did you bring your vaccination record card or other documentation? *(yes/no)*	☐	☐	
3. Have you ever had an allergic reaction to: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including either of the following:			
o Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
o Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
4. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

5. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (i.e., HIV infection, cancer)
- ☐ Take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of herparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists

Name: _____ Date of Birth: _____

Vaccines for Children (VFC) eligibility - Select if statement is true:

- o Patient is 19 years or younger
- o Patient is American Indian/Alaska Native
- o Patient is uninsured
- o Patient has insurance that does not cover vaccines
- o Patient is enrolled in CHIP

Consent: I understand the benefits and risks of the vaccine being given today, and ask that it be given to me or the person listed above for whom I am authorized to make consent.

1. I verify that I have been offered and have read (or had read to me) (1) the Emergency Use Authorization Fact Sheet for the COVID-19 Vaccine; (2) this COVID-19 Vaccine Consent Form for the Vaccine; and (3) any additional information provided to me concerning COVID-19 vaccination.
2. I acknowledge that I have had a chance to ask a medical professional questions about the COVID-19 Vaccine.
3. I understand that the Moderna Vaccine will be given in two separate doses four weeks apart, or the Pfizer-BioNTech Vaccine will be given in two separate doses 3 weeks apart.
4. I understand the known risks and the potential benefits of receiving the Moderna or Pfizer BioNTech Vaccine, and I understand there may be risks to the Moderna or Pfizer-BioNTech Vaccine that are not known at this time.
5. I understand that the FDA has authorized use of the Moderna and Pfizer-BioNTech Vaccines under an Emergency Use Authorization (EUA) and that there is currently not enough scientific evidence available for the FDA to fully approve this or any other COVID-19 vaccine.
6. I nonetheless request and consent to the Moderna or Pfizer-BioNTech COVID-19 Vaccine being given to me or my minor child. I attest that the minor receiving the vaccine is age 12 or above.
7. I understand it is recommended that I remain on site for at least 15 minutes after receiving the COVID-19 Vaccine and that, depending on the recommendations of medical professionals, I may be asked to remain on site longer for monitoring.
8. **I understand that receiving the vaccine at this location does not create a physician-patient relationship with any of the providers at Creekside Medical.**
9. I understand if I have concerns or questions after receiving the COVID-19 vaccine I need to call my own PCP or go to an Urgent Care. I acknowledge I will call 911 for a medical emergency.

Signature: _____ Date: _____

Relationship to Minor: _____

Administrative Use Only		
Print Name:	Date & Time:	
If yes answers, form reviewed by:		
Administered by:		
Immunization Given Today	Place label here:	Left Deltoid: ☐ Right Deltoid: ☐
Observed By:		
Waited for (please select one):	o 15 minutes o 30 minutes	
Observation Findings (please select one):	o No reaction o Reaction, please explain:	
Entered in eCW ☐		

Patient Registration Form (eCW)

PATIENT INFORMATION

(Please Print)

Patient's Name (Last)_____ (First) _____ (MI)____ Previous Name_____
Address _____
City, State _____ ZIP _____
Home Phone _____ Cell No. _____ Work Phone_____ Ext._____
Primary Care Provider (PCP) _____ Referred By_____
E-Mail Address _____
Date of Birth MM_____/DD_____/YYYY_____ Sex ☐ F-Female ☐ M-Male ☐ Transgender
Race☐American Indian/Alaska Native ☐Asian☐Native Hawaiian/Pacific Islander☐Black/African American☐White ☐Hispanic☐Other ☐Declined
Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino ☐ Declined
Language ☐English ☐Spanish ☐Indian ☐Japanese ☐Chinese ☐Korean ☐French ☐German ☐Russian ☐Other _____
Marital Status ☐Married ☐Single ☐Divorced ☐Widowed ☐Legally Separated ☐Partner
Employer Name_____
Employment Status ☐1 – Full-Time ☐2 – Part-Time ☐3 – Not Employed ☐4 – Self-Employed ☐5 – Retired ☐6 – Active Military
Student Status ☐F – Full-Time Student ☐P – Part-Time Student ☐N – Not a Student
Emergency Contact Last Name_____ First Name_____
Phone Number _____ Do you have a living will? ☐Yes ☐No
Emergency Contact Relationship to Patient _____ ☐ Guardian
Home Phone _____ Work Phone_____ Ext._____

RESPONSIBLE PARTY INFORMATION

(information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐
Responsible Party Name (Last)_____ (First) _____ (MI)_____
Guarantor Account Number _____ Date of Birth MM_____/DD_____/YYYY_____
Social Security Number _____ Telephone _____
E-Mail Address _____ Sex ☐ F - Female ☐ M - Male
Address Line 1 _____
City, State _____ ZIP _____
Employer _____ Employer Phone Number _____

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____)_____
Name of Insured _____Patient Relationship to Insured _____
Subscriber ID (Policy Number) _____Group ID _____Copay Amount _____
Effective Date _____Termination Date _____ Date of Birth MM_____/DD_____/YYYY_____

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____)_____
Name of Insured _____Patient Relationship to Insured _____
Subscriber ID (Policy Number) _____Group ID _____Copay Amount _____
Effective Date _____Termination Date _____ Date of Birth MM_____/DD_____/YYYY_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Legal Guardian) Signature _____ ***Date***_____

ASSIGNMENT OF BENEFITS AGREEMENTS/FINANCIAL POLICIES

Our office will accept an assignment of benefits from your insurance company. It is important to understand, though, that the contract regarding your medical benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies...

- I authorize Creekside Medical to submit medical claims to my insurance company on my behalf. I understand that the submission of a claim does not absolve me of my responsibility to ensure a claim is paid in full.
- I authorize my insurance company to pay Creekside Medical directly for services/treatment I have received.
- I authorize Creekside Medical to submit appeals; if my insurance company denies me benefits to which I am entitled.
- I authorize Creekside Medical to furnish and/or release any information necessary to my insurance company regarding treatment I received.
- I understand it is my responsibility to provide Creekside Medical with current insurance information. Failure to do so will result in getting a bill.
- I understand my co-pay is due at time of service and I may not be seen if I do not pay.
- Patients under 18 years of age will be the responsibility of the parent bringing them in for treatment regardless of custody agreements.
- Any returned checks will be charged a fee of $40.
- Delinquent accounts will be charged a $20 late fee and are subject to collection action.

Print Patient's Name:_____ **Date:**_____

Patient or Legal Guardian' Signature:_____