Wahiawā Health *302 California Ave Suite # 106 Wahiawa, Hi 96786*

Name: Last:	First:	Middle Initial:	
Date of Birth: Month:	Day:	Year:	**Phone #:**
Address:		**Apt/Room #:**	
City:	**State:**	**Zip Code:**	

Sex (gender assigned at birth)

- ☐ Female
- ☐ Male

Race

- ☐ American Indian or Alaska Native
- ☐ Asian (please specify) _____
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ Pacific Islander (please Specify) _____
- ☐ White
- ☐ Other (please Specify) _____

Ethnicity

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Unknown

Primary Insurance Carrier ID#:_____GRP#:_____
Insurance Company:_____Insurance Company Phone #: _____
Insured's Name:_____Relationship:_____Insured's DOB:_____
Secondary Insurance Carrier ID#:_____Grp#:_____
Insurance Company: _____Insurance Company Phone #:_____
Insured's Name:_____Relationship:_____Insured's DOB:_____

Is this the patient's 1st, 2nd, 3rd, or Booster Dose of the COVID-19 vaccine? (Please circle one)

FIRST **SECOND** ***THIRD** (*moderate to severely immunocompromised) ****Booster** (**bivalent)

If receiving a dose other than 1st dose, please fill out the following:

____/____/____ 1st dose received

____/____/____ 2nd dose received

____/____/____ 3rd dose received

____/____/____ most recent monovalent booster received

COVID Screen Questionnaire: Check each box that applies

	YES	NO
1. Are you feeling sick today?	☐	☐
2. In the last 10 days have you had fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, new loss of taste or smell, sore throat, congestion, runny nose, nausea, vomiting, or diarrhea?	☐	☐
3. Have you received a dose of COVID-19 vaccine? **If yes**, which vaccine product did you receive? ☐ Pfizer ☐ Janssen (Johnson & Johnson) ☐ Moderna ☐ Novavax ☐ Another product	☐	☐
4. Do you have a health condition or undergoing treatment that makes you moderately or severely immunocompromised? (This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.)	☐	☐
5. Is the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐
6. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐

7. **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 or a previous dose of COVID-19 vaccine?	☐	☐
• Another vaccine (other than COVID-19 vaccine) or an injectable medication?	☐	☐
• To something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies	☐	☐

8. **Check all that apply**.

☐ Have a history of myocarditis or pericarditis? ☐ History of prior COVID-19 disease within the last 3 months?

☐ Have a history of multisystem inflammatory syndrome (MIS-C or MIS-A)?

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 12 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Wahiawa Community Health Center, as an agent of the Hawaii Department of Health to administer the COVID-19 vaccine.

I understand that Pfizer's COMIRNATY vaccine has been approved by the FDA as of August 23, 2021 for individuals 16 years of age and older, and has been authorized for emergency use by the FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 12 years of age and older. I also understand that Moderna has not been approved or licensed by the FDA, but has been authorized for emergency use by the FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older; and the emergency use of these products are only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b) (1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner. I understand that the FDA amended the emergency use authorizations (EUAs) of the Moderna COVID-19 Vaccine and the Pfizer-BioNTech COVID-19 Vaccine to authorize bivalent formulations of the vaccines for use as a single booster dose at least two months following primary or booster vaccination for individuals 18 years of age and older (Moderna) and 12 years of age and older (Pfizer-BioNTech)

I understand that it is not possible to predict all possible side effects or complications associated with receiving this vaccine (s). I understand the risks and benefits associated with the above vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation. If I experience a severe reaction, I will call 911 or go to the nearest hospital.

On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Wahiawa Health, their employees, officers, directors, and contractors from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.

I acknowledge that I have been advised that Wahiawa Health makes no firm guarantees regarding administration of subsequent vaccines. Vaccine supply is dependent on Federal allotment to the state of Hawaii and is not in control of the health center.

I acknowledge that: (a) I understand the purpose/ benefits of Vaccine Administration Management System immunization registries and (b) Wahiawa Health will include my personal information and personal immunization information to be shared with the State of Hawaii Department of Health (DOH) and with the Centers for Disease Control (CDC, and/) or other federal agencies.

I acknowledge receipt of the Notice of Privacy Rights.

I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.

Signature of Patient/Authorized Representative: _____ **Date:** _____

Print name of Representative and Relationship: _____

Form reviewed by: _____ **Date:** _____

Pharmacist Verification: _____ **Date:** _____