Redwoods Rural HEALTH CENTER

Family Health Care

Registration and Informed Consent for COVID-19 Immunization

PARTICIPANT'S INFORMATION

Patient Name: _____ **Race/Ethnicity:** _____

Birthdate: _____ **Gender:** □ F □ M □ Other: _____ **Phone:** _____

Address: _____

Mother's First Name (required): _____

Do you have any of the following health conditions? □ Asthma □ Serious Heart Condition □ Liver Disease □ Chronic Lung Disease □Diabetes □ Severe Obesity □ Immunocompromised □ Unknown

PARENT/GUARDIAN OR AUTHORIZED PERSON INFORMATION

I GIVE CONSENT for the child/client named at the top of this form to be vaccinated and have reviewed and agree to the information included in this form.

Parent/Guardian First and Last Name: _____

Cell Phone or Home Phone Number: _____

PREVACCINATION CHECKLIST FOR COVID-19 IMMUNIZATION

1.Are you feeling sick today? □ Yes □ No □ Don't know

2. Have you ever received a dose of COVID-19 vaccine? □ Yes □ No □ Don't know

- **If yes, which vaccine product did you receive?**
  □ Pfizer □ Moderna □ Another product _____

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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)

- **A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures.** □ Yes □ No □ Don't know
- **Polysorbate.** □ Yes □ No □ Don't know
- **A previous dose of COVID-19 vaccine.** □ Yes □ No □ Don't know

4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? □ Yes □ No □ Don't know

(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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)

5. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies. □ Yes □ No □ Don't know

PREVACCINATION CHECKLIST FOR COVID-19 IMMUNIZATION - continued

6. Have you received any vaccine in the last 14 days?	□ Yes	□ No	□ Don't know
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	□ Yes	□ No	□ Don't know
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	□ Yes	□ No	□ Don't know
9. Do you have a weakened immune system caused by something such as HIV infection or cancer, or do you take immunosuppressive drugs or therapies?	□ Yes	□ No	□ Don't know
10. Do you have a bleeding disorder or are you taking a blood thinner?	□ Yes	□ No	□ Don't know
11. Are you pregnant or breastfeeding?	□ Yes	□ No	□ Don't know

INFORMED CONSENT – PLEASE READ AND SIGN

My signature below indicates that:

- I am of legal age or am the parent/guardian of the minor patient or am the authorized representative of the patient and am authorized to execute this consent form.
- I have reviewed this consent form and have read and understand the "Fact Sheet for Recipients and Caregivers" Emergency Use Authorization (EUA) / Vaccine Information Statement(s) (VIS) for the vaccine to be administered.
- I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.
- I understand the benefits and risks of the vaccine(s) and have voluntarily chosen to receive the vaccination.
- I will immediately alert the provider of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine.
- I understand I should remain in the area for 15 minutes after the vaccination for observation, or 30 minutes if I have any history of severe allergic reaction or anaphylaxis.
- In regards to minor: I understand I am not required to accompany the minor named above to the vaccination appointment and, by giving my consent below, the minor will receive the FDA approved emergency use vaccine to prevent COVID-19 whether or not I am present at the vaccination appointment.
- I understand that as required by state law (Health and Safety Code, § 120440), all immunizations will be reported to the California Immunization Registry (CAIR2). I understand the information in the child's CAIR2 record will be shared with the local health department and State Department of Public Health, shall be treated as confidential medical information, and shall be used only to share with each other or as allowed by law. I may refuse to allow the information to be further shared and can request the CAIR2 record be locked by visiting the Request to Lock My CAIR Record web form.

_____ _____

Participant/Guardian/Authorized Representative Signature Date

OFFICE USE ONLY

MANUFACTURER	LOT #	EXP DATE TIME OPENED	DATE GIVEN TIME GIVEN	SITE	GIVEN BY	DOSE #
Pfizer-BioNTECH				□ RD □ LD		
Moderna				□ RD □ LD		
Janssen				□ RD □ LD		

Form reviewed by: _____ Date: _____