COVID-19 Vaccination Consent under Emergency Use Authorization

Saint Louis COUNTY PUBLIC HEALTH

PATIENT INFORMATION

Last Name: | **First Name:** | **Middle Initial:**

Date of Birth: / / **Age on this date:**

HEALTH HISTORY

		YES	NO	UNKNOWN
1.	Are you feeling sick today?	☐	☐	☐
2.	Have you ever received a dose of COVID-19 vaccine? • If yes, which vaccine product ☐Pfizer ☐Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____ Date of all previous COVID-19 vaccines:_____ _____	☐	☐	☐
3.	Have you ever had a severe 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 either of the following: ○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
	○ 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 a severe allergic reaction (e.g. anaphylaxis) 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 occurred within 4 hours 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
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ 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 bleeding disorder
- ☐ Take a blood thinner Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Have received dermal fillers
- ☐ History of Guillain-Barré Syndrome (GBS)
- ☐ Have a history of fainting with vaccinations or blood draws
- ☐ Am currently pregnant or breastfeeding

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3RD DOSE ELIGIBILITY

6. I have a weakened immune system (i.e. HIV infection, cancer) or take immunosuppressive drugs or therapies for one of the following conditions:

- ☐ Active treatment for solid tumor and hematologic malignancies
- ☐ Receipt of solid-organ transplant and taking immunosuppressive therapy
- ☐ Receipt of CAR-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy)
- ☐ Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)
- ☐ Advanced or untreated HIV infection
- ☐ Active treatment with high-dose corticosteroids (i.e., ≥20mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory

BOOSTER DOSE ELIGIBILITY

7. It has been 6 months since my second vaccination, and I am:

- ☐ I am 65 year of age or older
- ☐ I reside in a long-term care facility
- ☐ I am 50-64 with an underlying medical condition*
- ☐ I am 18-49 with an underlying medical condition*
- ☐ I am 18-64 and am at an increased risk of COVID-19 exposure or transmission because of my occupation or living in an institutional setting (correctional facility, group home, etc.)

* Underlying medical conditions include:

Cancer	Chronic kidney disease	Dementia/neurologic conditions
Down syndrome	HIV	Liver disease
Overweight/Obesity	Pregnancy	Sick cell disease/thalassemia
Smoking	Stroke/CVD	Substance use disorders
Heart conditions (HF, CAF, cardiomyopathy, HTN)	Chronic lung disease (COPD, asthma, ILD, CD, pulm HTN)	Other immune compromise

_____By initialing here, I confirm that I have one of the conditions or risks above and I desire a third dose of an mRNA vaccine.

St. Louis County DPH recommends that patients 18-49 with underlying medical conditions and patients 18-64 with occupational or institutional exposures consider their individual risks and benefits of vaccination and consult with their healthcare provider if support is needed before vaccination.

CLINICAL STAFF ONLY

Injection Site	**Manufacturer**	**Dose #**	**Lot #:**	**Administered by/ date**
☐ Left Arm ☐ Right Arm ☐ Other:	☐ Pfizer ☐ Moderna ☐ Janssen *(Johnson & Johnson)*	☐ 1 ☐ 2 ☐ 3	**Expiration date:**	

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CONSENT TO VACCINATE

I have been provided and have read, or had explained to me the vaccine information sheet about the COVID-19 vaccination. I understand that for Pfizer and Moderna vaccine, two to three doses will need to be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (or ensured the person named above for whom I am authorized to provide consent was given a chance to ask questions). I understand the benefits and risks of the vaccination as described. I understand there may be risks to the vaccine that are not known at this time. I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide consent). I understand that it is recommended that I remain on site for at least 15 minutes after receiving the vaccine and that, depending on the recommendations of medical professionals, I may be asked to remain on site longer for monitoring.

PREP ACT NOTICE

The federal Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICP (Countermeasures Injury Compensation Program) to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The COVID-19 vaccine is a covered countermeasure. The CICP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use of covered countermeasures identified in a PREP Act declaration. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV–2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any such product. Information about the CICP and filing a claim is available by calling 1-855-266-2427 or visiting https://www.hrsa.gov/cicp.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that I have received or have been advised of the St. Louis County Department of Public Health's Notice of Privacy Practices and where I can obtain any revisions made to this Notice.

Printed Name

Signature of Patient/Guardian/Legal Representative	**Relationship to Client (if applicable)**	**Today's Date** / /