FLORIDA DEPARTMENT OF HEALTH IN ORANGE COUNTY
COVID-19 VACCINE SCREENING AND CONSENT FORM
COVID-19 Vaccine

SECTION 1: INFORMATION ABOUT YOU (PLEASE PRINT)

Last Name	First Name	Middle Name

Date of Birth			Age in Years:	Sex (Gender assigned at birth)
Month	Day	Year		☐ Male ☐ Female

Race				Ethnicity
☐American Indian or Alaska Native	☐Native Hawaiian or Other	☐Other Asian	☐Other	☐Hispanic or Latino
☐Asian	☐Pacific Islander	☐Other Nonwhite		☐Not Hispanic or Latino
☐Black or African American	☐White	☐Other Pacific Islander		☐Unknown

Address		
City	State	Zip Code
Cell Phone Number		

Is this the patient's first or second dose of the COVID-19 vaccination? ☐ First Dose ☐ Second Dose

If 2nd Dose provide the following information:

1st Dose date received:	1st Dose Manufacturer ☐ Moderna ☐ Pfizer 1st Dose lot #:

SECTION 2: COVID-19 SCREENING QUESTIONS

Please check YES or NO for each question.	YES	NO
1. Do you have today or have you had at any time in the last 10 days a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?		
2. Have you tested positive for and/or been diagnosed with COVID-19 infection within the last 10 days?		
3. Have you had a severe allergic reaction (e.g. needed epinephrine or hospital care) to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
4. Have you had any other vaccinations in the previous 14 days?		
5. Have you had any COVID-19 Antibody therapy within the last 90 days (e.g. Regeneron, Bamlanivimab, COVID Convalescent Plasma, etc.)		

SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE

Please check YES or NO for each question.	YES	NO
6. Do you carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, foods, vaccines or latex?		
7. For women, are you pregnant or is there a chance you could become pregnant?		
8. For women, are you currently breastfeeding?		
9. Are you immunocompromised or on a medication that affects your immune system?		
10. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		

- I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the patient and confirm that the patient is at least 16 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Florida Department of Health (DOH) or its agents to administer the COVID-19 vaccine.
- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by 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 this product is 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 it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 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 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the State of Florida, the Florida Department of Health (DOH), and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees 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: (a) I understand the purposes/benefits of Florida SHOTS, Florida's immunization registry and (b) DOH will include my personal immunization information in Florida SHOTS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize DOH or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to DOH or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if DOH invoices me after the time of service, upon receipt of such invoice.
- I acknowledge receipt of the Notice of Privacy Rights.

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

Print Name of Representative and Relationship to Person Receiving Vaccine: _____

Patient Email Address:	

Site (LD/RD)	Route	Manufacturer (MVX)	Lot #Unit of Use/ Unit of Sale	Expiration Date	Date of EUA Fact Sheet
	IM				

Administered at Location (Facility Name):	

Vaccinator (Print Name):		Signature:		Date:	