Jefferson Healthcare

Place patient label here

COVID-19 Vaccine Patient Acknowledgment and Administration Record

PATIENT INFORMATION

Last Name: First Name: Middle Name: Birth Date: Age:

Race/Ethnicity (*optional – for reporting purposes*):

Preferred Language (*check one*):

English □	Spanish □	Other: _____ □

Sex Listed at Birth:

Male: □	Female: □

Gender identity (*optional - for reporting purposes*):

Male: □	Female: □	Non-Binary □	Unspecified/Indeterminant: □

Mailing Address: City: State: Zip:

Primary Telephone Number: Email Address: Medicare Part A/B # (if applicable):

( )

FOR UNINSURED PATIENTS:

☐ By checking this box I attest that the following is true and accurate: I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government funded health benefit plan. I understand that to have my COVID-19 vaccine administration fee paid for by the U.S. Health Resources and Services Administration (HRSA) COVID-19 Program for Uninsured Patients I must provide one of the following: (a) my Social Security Number, (b) my state identification number (with state of issuance), or (c) my driver's license number (with state of issuance).

Number (SSN/ID/License – *circle one*): _____ State: _____

COVID-19 Immunization Acknowledgements

I have been given a copy of and have read (or have had explained to me) the information in the Emergency Use Authorization Fact Sheet for Vaccine Recipients and Caregivers or the Vaccine Information Statement for the vaccine I am receiving, and that it contains information about potential side effects and adverse reactions. I have had a chance to ask questions about the Fact Sheet/VIS, the vaccine itself and this form, which were all answered to my satisfaction.

I understand that the vaccine I am receiving has been authorized by the U.S. Food and Drug Administration (FDA) for emergency use, pursuant to an Emergency Use Authorization and not the normal FDA approval process. I understand the benefits, alternatives and risks of receiving the vaccine to the extent they are known and unknown at this time. I understand that, as with all vaccines, there is no guarantee that I will become immune to COVID-19 or that I will not experience side effects. I have decided to receive the COVID-19 vaccine voluntarily and freely. I understand that I always have the option to refuse the vaccine or to request a different vaccine, if available. I understand that if my vaccine is a two-dose vaccine I must receive the same vaccine for each dose, and that if I do not receive the second dose I may be less likely to become immune to COVID-19. I assume full responsibility for any result or reaction if I choose to receive the vaccine, and I hereby request that the vaccine be given to me or to the person named above for whom I am legally authorized to make this request.

I understand that I must remain in the vaccine administration area identified by my health care provider for at least 15 minutes (or 30 minutes, if I have any history of allergic or other adverse reactions to vaccines) after vaccination to be monitored for any adverse reaction. I understand that if I experience any suspected adverse reaction or side effects at any time, including but not limited to difficulty breathing, swelling of my face and/or throat, a fast heartbeat, rash all over my body or dizziness and weakness, I should contact my health care provider immediately.

In addition, if I am receiving the Janssen/Johnson & Johnson vaccine, I understand that the CDC and FDA have reviewed reports of adverse events following use of the Janssen/Johnson & Johnson vaccine suggesting an increased risk of a rare adverse event called thrombosis with thrombocytopenia syndrome (TTS), which involves blood clots with low platelets. I understand that nearly all reports involve adult women between 18 and 50 years old. This adverse event is rare, occurring at a rate of less than 1 event per 140,000 women between 18-50 years of age who receive the vaccine. I further understand that both CDC and FDA recommend continued use of this vaccine based on available data showing that the risk of severe illness or death from COVID-19 infection remains much greater than the risk of this rare adverse event resulting from this vaccine. In addition to the potential adverse reaction symptoms listed above, I understand that for three weeks after receiving the Janssen/Johnson & Johnson vaccine I should be alert for possible symptoms of a blood clot with low platelets, including but not limited to: severe or persistent headaches or blurred vision, shortness of breath, chest pain, leg swelling, persistent abdominal pain and easy bruising or tiny blood sports under the skin beyond the injection site. If I observe any of these symptoms I should contact my health care provider immediately.

X_____ _____

Signature of Patient/Authorized Representative **Date**

_____

Printed Name of Authorized Representative

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Authorization to Request Payment: I authorize Jefferson Healthcare to release my health information and request payment. I certify that the information I have provided in applying for payment under Medicare, Medicaid or other insurance or government funded health benefit program is true and correct. I request that payment of authorized benefits be made on my behalf, and I hereby authorize release of all records necessary to act on this request.

Disclosure of Records: I understand and agree that Jefferson Healthcare may be required to or may voluntarily disclose my health information to my primary care physician, my insurance plan, other health systems or hospitals, and state and federal agencies or registries, for purposes of treatment, payment or health care operations or for other purposes authorized or required by law. I understand that Jefferson Healthcare will use and disclose my health information according to its Notice of Privacy Practices, which I have received or I may obtain at any time upon my request on Jefferson Healthcare's website.

Authorization to Disclose to Jefferson Healthcare Employee Health *(for JH Employees Only)*: I authorize this vaccine acknowledgment and administration record to be disclosed to and used by Jefferson Healthcare Employee Health for occupational health/employment purposes, and I authorize Jefferson Healthcare to maintain my vaccine records in both my electronic health record (i.e. Epic) and my employee health record to the extent required or permitted by law.

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

_____
Printed Name of Authorized Representative

ALL SECTIONS BELOW ARE REQUIRED AND FOR OFFICIAL USE ONLY

COVID-19 VACCINE ADMINISTRATION RECORD

Administration date: _____ Administration time: _____

CVX (Product): _____

Dose number (1 or 2): _____

IIS Recipient ID: _____

IIS vaccination event ID: _____

Lot number: _____

Unit of Use MVX (Manufacturer): _____

Sending organization: _____

Vaccine administering provider suffix: _____

Vaccine administering site on the body: Left deltoid □ Right deltoid □ Other □ (indicate location) _____

Vaccine expiration date: _____

Vaccine route of administration: _____

Vaccination series complete (date): _____

Fact Sheet for Vaccine Recipients and Caregivers version date: _____

JH Facility/Clinic Name/ID Where Vaccine Administered: **County: Jefferson (WA)**

_____

X_____ _____
Printed name, signature and title of clinical staff administering vaccine **Date**

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

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.

Name _____

Age _____

	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 _____			
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 a 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.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
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 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, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
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?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Do you have a history of or a risk factor for a blood clotting disorder?			
12. Are you pregnant or breastfeeding?			
13. Do you have dermal fillers?			

Form reviewed by _____ **Date** _____

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