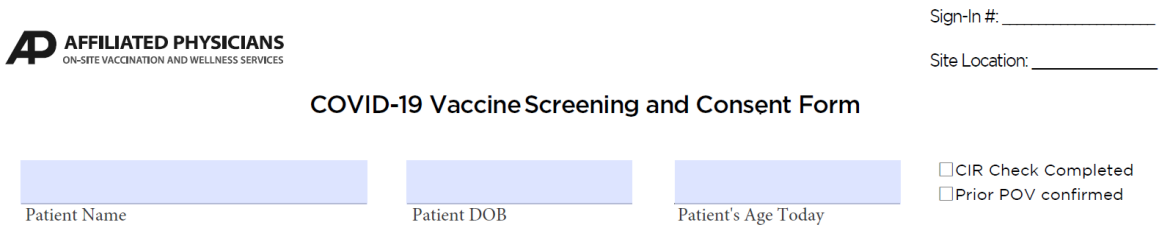
COVID Hard Copy Consent

Consent - Page 1 Overview


AFFILIATED PHYSICIANS
ON-SITE VACCINATION AND WELLNESS SERVICES

Sign-In #: _____

Site Location: _____

COVID-19 Vaccine Screening and Consent Form

Patient Name | Patient DOB | Patient's Age Today

☐CIR Check Completed
☐Prior POV confirmed

- Must include First and Last Name and must be legible
- Confirm Patient's DOB: 2-digit month, 2-digit date, 4-digit year i.e. 04/15/2022
- Must calculate patient's age when DOB has been confirmed and ask for verbal confirmation. i.e. How old are you today?
- Confirm that CIR check has been completed.
- Confirm POV provided showing prior vaccinations.
- Sign-in # and Site Location must be placed on the **upper right corner of Consent Form on both page 1 and page 2.**

The following Section should be completed by AP STAFF ONLY. This section must be fully completed.

This section MUST be completed by STAFF:

1. Is patient getting a primary series dose today? ☐Yes ☐ No **2. Is patient IC today?** ☐ **Yes** ☐ **No** **3.** If **'Yes',** Is patient newly IC since last dose of COVID vaccine? ☐Yes ☐ No ☐ N/A

4. What date was patient's last COVID vaccine dose? ☐ N/A or ____|____|____

5. **Purpose for Paper Consent**

☐ Early Dose [for D2 ONLY] ☐ IC status CHANGED; out-of-order dosing ☐ J/J primary + B1 patient age 18-49 seeking B2

☐ International 12-17yo Moderna seeking follow up dose(s) {Pfizer} ☐ Other **[CALL HL]** _____

- Confirm if patient is receiving a dose of their primary series.
- Confirm if patient is IC today.
  - If 'Yes', confirm if they are newly IC.
  - If 'No', then check the N/A box.
- Confirm the date of patient's last COVID vaccine dose.
  - If patient is receiving a COVID vaccine dose for the first time, check the N/A box.
- Make sure to check off the 'purpose' for completing appointment on paper consent, instead of completing in the EMR.

The following Section should be completed by patient and confirmed by registration.

This section MUST be completed by PATIENT:

1. I received and tolerated my **LAST COVID** vaccination? ☐Yes ☐ No ☐ N/A **and it WAS?** ☐ Pfizer ☐ Moderna ☐ Other_____

2. I am receiving my ☐ Dose 1, ☐ Dose 2 or ☐Additional Primary Dose today? ☐ Yes ☐ No

3. I am receiving a BOOSTER Dose today? ☐ Booster 1 ☐ Booster 2 or ☐ Other _____ ☐ Yes ☐ No

4. I attest I am moderately to severely immunocompromised? ☐ Yes ☐ No

4a. If 'Yes', I am on ☐ **Medication** or have a ☐ **Condition** that puts me at high risk. i.e. cancer, transplant, chronic disease, etc.

- Confirm what vaccine patient received prior to today. Answer 'Yes' or 'No'. Patient should check N/A if this is patients first COVID vaccine dose.
- Confirm if patient is receiving a Primary Dose (D1, D2 or AD) today or if patient is receiving a Booster Dose.
- Confirm if patient is moderately to severely Immunocompromised (IC) and patient needs to check off 'Condition' and/or 'Medication' boxes.

The following Section should be completed by patient and confirmed by registration.

SCREENING QUESTIONNAIRE

If 'Yes' to Questions 5-11 below, WILL NOT Disqualify Patient

1. Have you ever had a severe or life-threatening reaction to a COVID vaccine? ☐ Yes ☐ No
2. Do you currently feel sick? ☐ Yes ☐ No
3. Are you running a fever of 100.4 or > today? ☐ Yes ☐ No
4. Have you been asked to isolate due to COVID infection or exposure within the past 10 days? ☐ Yes ☐ No

If 'Yes' to any screening question 1 - 4 you will be asked to return at a later date.

5. Have you been sick with COVID within the past 3 months? ☐ Yes ☐ No
6. Do you have a history of having a severe allergic reaction to anything, other than the COVID vaccine? ☐ Yes ☐ No
7. Do you have a history of syncope or vasovagal? [feeling faint or passing out] ☐ Yes ☐ No

If 'Yes' to screening question 6 or 7, observation time may be extended.

8. Do you have a history of Blood Clots or Bleeding Disorder? ☐ Yes ☐ No
9. Do you have a history of Myocarditis or Pericarditis? ☐ Yes ☐ No
10. If 'Yes' to question 8 or 9, did the illness occur after receiving a COVID vaccine? ☐ Yes ☐ No ☐ N/A
11. Did you receive **MONOCLONAL antibodies** for treatment of COVID within past 3 months? ☐ Yes ☐ No

- All questions need to be answered by patient verbally at time of appointment.
- Questions 1-4 are disqualifying questions. If answered 'Yes', patient must return at a later date to receive their vaccination.
- Questions 6 or 7, if answered 'Yes' will require a longer observations period of at least 30 minutes. If patient refuses to stay for observation, document in EMR or paper consent, whichever is being utilized.
- Questions 5-11 are NOT disqualifying questions. If answered 'Yes' or 'No', patient may still consent to treatment.

Consent Section

As the patient / the patient's surrogate, I affirm that I have been provided and have read (or has been explained to me) the information sheet about COVID-19 vaccination. I attest I have had op[illegible]y to ask questions of which have been answered to my satisfaction. I understand the benefits and risks of vaccination. I understand all COVID vaccinations are reported t[illegible]egistry for vaccine tracking purposes. I request that the COVID-19 vaccination be given to me or above named person, for whom I am authorized to provide surrogate consent[illegible]stand I may request a copy of Affiliated Physicians Notice of Privacy Practice at any time and it shall be provided to me. I understand there will be no cost to me for this vaccin[illegible]erstand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health ins[illegible]ian, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to me[illegible]ords, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

☐ * I hereby certify under penalty of law that the information presented herein is true and accurate; and that I am, or the person for whom I am legally authorized to make healthcare decisions is, 12 years of age or older and resides in the United States. I understand that knowingly providing false information on this form is a class A misdemeanor and may result in up to a year in jail or a $1,000 fine. Minors must have parental, guardian, or legal custodian consent, unless the minor is part of a group to whom the law gives the right to consent to their own care (e.g., married minors, minors who are parents or pregnant, and minors in the military).

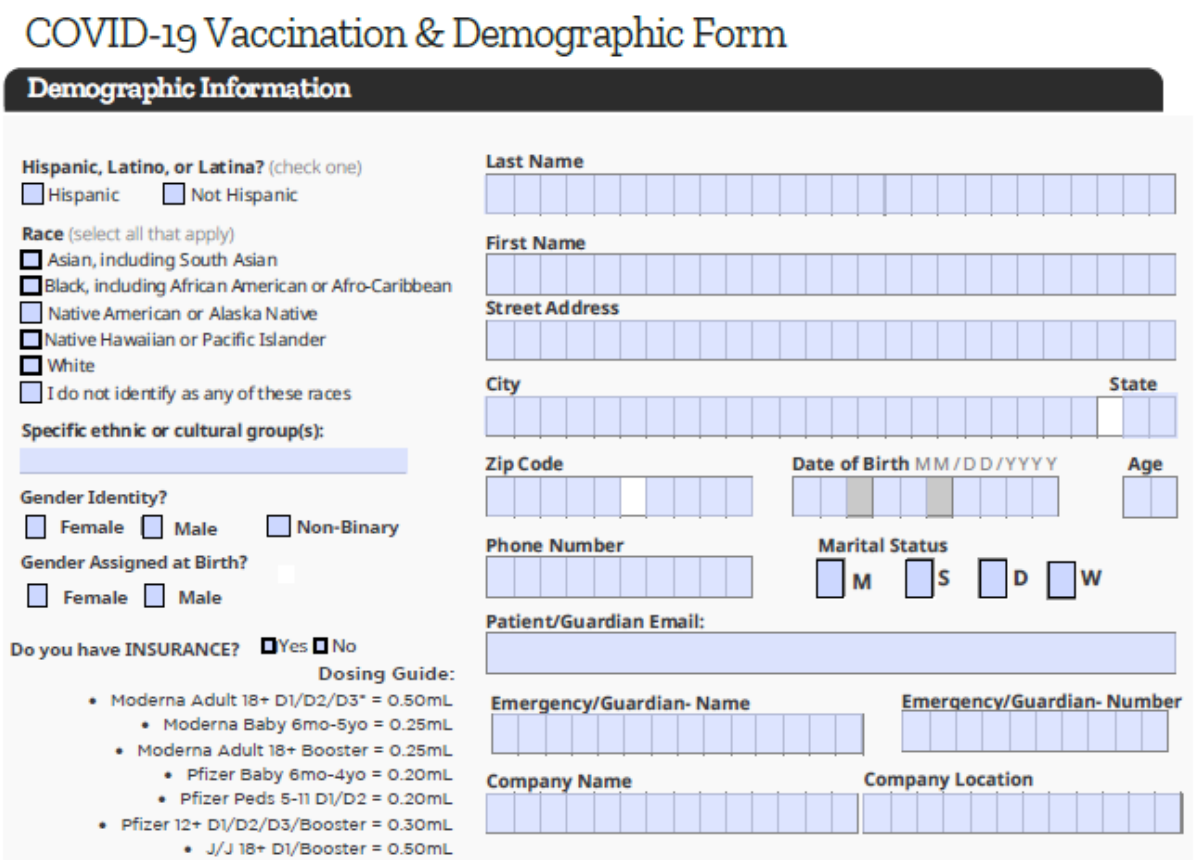
Date:___|___|___Time:_____

Patient/Guardian/Surrogate Printed Full Name **Patient/Guardian/Surrogate Signature**

Witness Printed Full Name **Witness Signature** NYCDOH v06.02.22

- Highlighted area above must be read and confirmed by patient or patient's guardian/surrogate. Patient must check the box next to this section, print full name on the line provided and sign.
- Date and Time of consent must be recorded.
- Witness full name and signature is for the AP staff ONLY. Not to be completed by a family member.

Consent – Page 2 Overview



COVID-19 Vaccination & Demographic Form

Demographic Information

Hispanic, Latino, or Latina? (check one)
☐ Hispanic ☐ Not Hispanic

Race (select all that apply)
☐ Asian, including South Asian
☐ Black, including African American or Afro-Caribbean
☐ Native American or Alaska Native
☐ Native Hawaiian or Pacific Islander
☐ White
☐ I do not identify as any of these races

Specific ethnic or cultural group(s):

Gender Identity?
☐ Female ☐ Male ☐ Non-Binary

Gender Assigned at Birth?
☐ Female ☐ Male

Do you have INSURANCE? ☐Yes ☐No

Dosing Guide:
- Moderna Adult 18+ D1/D2/D3* = 0.50mL
- Moderna Baby 6mo-5yo = 0.25mL
- Moderna Adult 18+ Booster = 0.25mL
- Pfizer Baby 6mo-4yo = 0.20mL
- Pfizer Peds 5-11 D1/D2 = 0.20mL
- Pfizer 12+ D1/D2/D3/Booster = 0.30mL
- J/J 18+ D1/Booster = 0.50mL

Last Name

First Name

Street Address

City **State**

Zip Code **Date of Birth** MM/DD/YYYY **Age**

Phone Number **Marital Status** ☐ M ☐ S ☐ D ☐ W

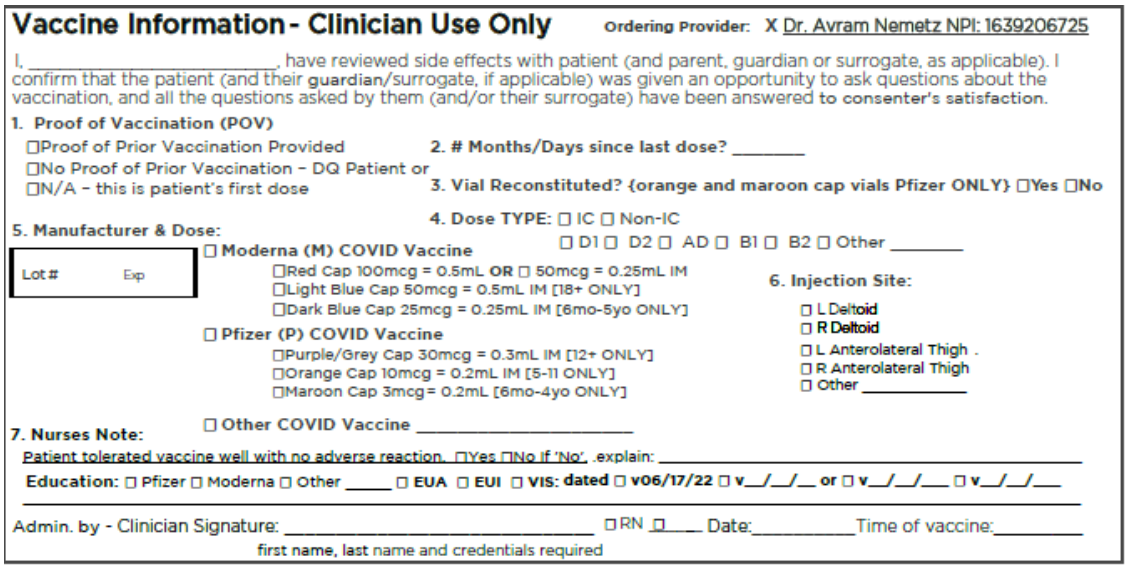
Patient/Guardian Email:

Emergency/Guardian- Name **Emergency/Guardian- Number**

Company Name **Company Location**

- Demographics Information must be completed thoroughly by AP staff with the help of patient. If translator required, must use translation line.
- Must **include Ethnicity, Gender Identity, Gender Assigned at Birth, and Insurance status** located in the left margin of page 2.
- Dosing Guide is visible for nurse reference when vaccinating. Make sure to double and triple check dose volume and manufacturer are correct before administering.

- RN - print first and last name.
- Must document Pt POV Status.
- Document Dose Type Admin.
- Check off Manufacturer Type.
- Input Lot # and Exp Date.
- Check off Dose/Volume, Injection Site, EUA/EUA provided w/ date.
- Confirm 'Yes' or 'No', patient tolerated with no adverse reactions. And lastly, sign, add credentials, date and time of vaccination.



Vaccine Information - Clinician Use Only **Ordering Provider:** X Dr. Avram Nemetz NPI: 1639206725

I, _____, have reviewed side effects with patient (and parent, guardian or surrogate, as applicable). I confirm that the patient (and their guardian/surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered to consenter's satisfaction.

1. Proof of Vaccination (POV)
☐Proof of Prior Vaccination Provided
☐No Proof of Prior Vaccination – DQ Patient or
☐N/A – this is patient's first dose

2. # Months/Days since last dose? _____

3. Vial Reconstituted? {orange and maroon cap vials Pfizer ONLY} ☐Yes ☐No

4. Dose TYPE: ☐ IC ☐ Non-IC
☐ D1 ☐ D2 ☐ AD ☐ B1 ☐ B2 ☐ Other _____

5. Manufacturer & Dose:
Lot # Exp
☐ **Moderna (M) COVID Vaccine**
☐Red Cap 100mcg = 0.5mL **OR** ☐ 50mcg = 0.25mL IM
☐Light Blue Cap 50mcg = 0.5mL IM [18+ ONLY]
☐Dark Blue Cap 25mcg = 0.25mL IM [6mo-5yo ONLY]
☐ **Pfizer (P) COVID Vaccine**
☐Purple/Grey Cap 30mcg = 0.3mL IM [12+ ONLY]
☐Orange Cap 10mcg = 0.2mL IM [5-11 ONLY]
☐Maroon Cap 3mcg= 0.2mL [6mo-4yo ONLY]
☐ **Other COVID Vaccine** _____

6. Injection Site:
☐ L Deltoid
☐ R Deltoid
☐ L Anterolateral Thigh
☐ R Anterolateral Thigh
☐ Other _____

7. Nurses Note:
Patient tolerated vaccine well with no adverse reaction. ☐Yes ☐No If 'No', explain: _____
Education: ☐ Pfizer ☐ Moderna ☐ Other _____ ☐ **EUA** ☐ **EUI** ☐ **VIS: dated** ☐ **v06/17/22** ☐ **v__/__/__ or** ☐ **v__/__/__** ☐ **v__/__/__**

Admin. by - Clinician Signature: _____ ☐RN ☐____ Date:_____Time of vaccine:_____
first name, last name and credentials required