**Page 1**

**BOOSTER**

**NPI:1649213125**

**COVID-19 VACCINE HEALTHSCREEN/CONSENT**

**Business Name:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| \*Full Name: | | \*Date of Birth:  **/ /** | | | Age: | \*Gender:  M F X |  |
| \*Street Address: | | \*Town/City: | | | | \*Zip Code: | Daytime Phone: |
| Hispanic or Latino?  Circle One: YES/NO | Race: | | | | | Email Address: | |
| \***Required \*\* MUST BE 18 OR OVER**  Is this person un-insured? | | | * yes | * n o |
| Is this person insured by MaineCare (Medicaid)? | | |  yes |  no |
| MaineCare ID #:  Does this person have private Insurance? | | |  yes |  no |

**Name of Insurance Company**:

**ID Number**: Group Number:

**Subscriber Name**: Subscriber Date of Birth:

Doctor’s Name: Phone Number:

**Please answer the following questions about the person named above.** Comments may be written on the back of this form. **Yes No Unknown**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **1) Are you 18 years of age or older**? |  |  |  |
| 1. 2) Are you feeling sick today? |  |  |  |
| 1. 3) Have you ever had a severe allergic reaction that required epinephrine or hospitalization? |  |  |  |
| 1. 4) If so, was the severe allergic reaction after receiving a vaccine or other injectable? Which one? |  |  |  |
| 1. 5) Have you ever received a dose of COVID-19 vaccine?   **Which Product**? **Dates:** |  |  | N/A |
| 1. 6) Have you received passive antibody therapy as treatment for COVID-19? |  |  |  |
| 1. 7) Do you have a bleeding disorder or are you taking a blood thinner? |  |  |  |
| 1. 8) Is your immune system compromised at this time? |  |  |  |
| 1. 9) Do you have a history of Guillain-Barré Syndrome (GBS)? |  |  |  |
| 1. 10) Have you received dermal fillers? |  |  |  |
| 1. 11) Do you have a history of heparin-induced thrombocytopenia (HIT)? |  |  |  |
| 1. 12) Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection? |  |  |  |
| 1. 13) Do you have a history of myocarditis or pericarditis? |  |  |  |
| 1. 14) Are you pregnant or breastfeeding, or plan to be in the near future? |  |  |  |

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|  |  |
| --- | --- |
| Name: | \*Date of Birth:  **/ /** |

**PERMISSION TO VACCINATE**

* I was given a copy of the COVID-19 EUA fact sheet for the booster vaccine I am to receive and have read it or had it read and explained to me. I have had an opportunity to ask questions and I understand the benefits and risks of the COVID-19 vaccine.
* I give permission for a record of this vaccination to be entered into the Maine ImmPact Registry.
* I give permission for information to be used to bill MaineCare or private insurance for the cost of administration of the vaccine.
* I understand that I am advised to stay on site today for at least 15 minutes post vaccination and may be further advised to stay for 30 minutes.
* **By signing below, I give permission for the COVID-19 vaccine to be given to the person named above.**

**X Date:**

**Signature of parent/guardian or adult to be vaccinated (also, print name and relationship if different from person named at top of form)**

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|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Vaccine**  **Test/**  **Treatment** | **Date**  **Given** | **Initials of authorizing person** | **EUA**  **DATE** | Manufacturer **And lot #** | **Site:**  **Deltoid**  **(Circle one)** | **Dosage and route** | **Provider**  **Signature and Title** |
| **Moderna** |  |  | **10/20/2021** | **Moderna**  **033F21A EXP 12/31/2069** | **L**  **R** | **0.25c IM** |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Vaccine**  **Test/**  **Treatment** | **Date**  **Given** | **Initials of authorizing person** | **EUA**  **DATE** | Manufacturer **And lot #** | **Site:**  **Deltoid**  **(Circle one)** | **Dosage and route** | **Provider**  **Signature and Title** |
| **Janssen/ J&J** |  |  | **10/20/2021** | **Janssen/ J&J** | **L**  **R** | **0.5cc IM** |  |

UMMS Provider Code: 116737176 V-Safe sheet given? Y