PAT WALKER HEALTH CENTER, UNIVERSITY OF ARKANSAS
COVID-19 VACCINE IMMUNIZATION CONSENT FORM

(Legal) First Name: ______________________ **MI:** ____ **Last Name:** _____________________ **UA ID#**_____________

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ **Gender:** ☐ Male ☐ Female **Phone:**___________________________

Street Address (local): ____ **P.O. Box** ___________ **Apt. No.** __________

City: ____ **State:** ____________ **Zip Code:** ☐☐☐☐☐

Race: ☐White ☐Hispanic/Latino ☐Black/African American ☐Native American /Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐Other

	YES	**NO**
Have you had a previous COVID-19 vaccine? If yes, date?		
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?		
Have you ever had severe allergic reaction (anaphylactic reaction that required treatment with EpiPen or treatment at a hospital) to any vaccine (including Pfizer BioNTech, Moderna or Janssen COVID-19 vaccine), or vaccine component (including polyethylene glycol [PEG] in medications or laxatives and preparations for colonscopy) or immediate allergic reaction of any severity to polysorbate in vaccine, coated tablets or IV steroids (due to potential cross-reactive hypersensitivity with the vaccine ingredient PEG) or injectable therapy? This would include an allergic rection that occurred within 4 hours, such as difficulty breathing, hives, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness.		
Have you ever had a severe allergic reaction (anaphylaxis) to something other than a component of COVID-19 vaccine or any vaccine or injectable medication such food, pet, venom, environmental, oral medication allergies?		
Do you have a bleeding disorder or are you taking a blood thinner? If so, a fine gauge needle (23 gauge or smaller caliber) should be used to administer the vaccine, followed by firm pressure without rubbing for at least 2 minutes.		
Do you have dermal fillers? If swelling occurs at or near the filler injection site, usually face or lips, patient should contact their health care provider.		
Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive Pfizer- BioNTech, Moderna or Janssen COVID-19 vaccine. A discussion with your healthcare provider can help make informed decision.		
Are you immunocompromised? Do you have a condition that weakens your immune system? Are you receiving any immunosuppressive therapy? You are still eligible to receive Pfizer-BioNTech, Moderna or Janssen COVID-19 vaccine unless you have a contraindication for some other reason. However, you will need special counseling about the vaccine.		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Pfizer-BioNTech, Moderna or Janssen COVID-19 vaccine should be deferred for at least 90 days to avoid interference with vaccine-induced immune responses.		
NOTE: Recipients of Janssen COVID-19 vaccine should be instructed to seek immediate medical attention if they develop shortness of breath, chest pain, leg pain or swelling, persistent abdominal pain, neurological symptoms (including severe or persistent headaches or blurred vision), nausea, vomiting, petechiae or easy bleeding beyond the site of vaccination within 4 to 30 days of receipt of Janssen vaccine. Most people who have developed blood clots and low platelets were females ages 18 through 49 years		
NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine **is** due in 21 or 28 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date.		

RELEASE AND ASSIGNMENT: The Pat Walker Health Center's Notice of Privacy Practices is available at on site or at https://health.uark.edu/_resources/documents/patient_privacy/pwhc-medical-privacy-practice-notice-ferpa-oct-2018-signed.pdf

- **I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient Emergency Use Authorization Fact Sheet for each vaccine visit the website https://www.cdc.gov/vaccines/covid-19/eua/index.html or you may also visit the Local Health Unit or private provider to receive a printed copy of the EUA Fact Sheet.**
- **I give consent to this COVID-19 provider/staff for the individual named above to be vaccinated with COVID-19 vaccine.**
- **I hereby acknowledge that I have reviewed a copy of the Pat Walker Health Center's Notice of Privacy Practices.**
- **I understand that information about this COVID-19 vaccination will be included in (WebIZ) Arkansas Immunization Information System.**

To My Insurance Carrier(s):

- **I authorize the release of any medical information necessary to process my insurance claim(s).**
- **I authorize and request payment of medical benefits directly to this COVID-19 Provider/Pat Walker Health Center.**
- **I agree that the authorization will cover all medical services rendered until I revoke the authorization.**
- **I agree that the photocopy of this form may be used instead of the original.**

X Signature of Patient/Parent/Guardian____**DATE**____________________

Insurance Information:

☐ No Insurance

☐ Insurance Company Name: ______________________________________

Member ID Policy #: ____

Patient's Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder Information:

First Name: ______________________ MI: ____ Last Name: _______________________

Policy Holder Date of Birth: ____________________

Policy Holder's Employer Name: _______________________________________

Email address: ____

(Completed by staff only)

COVID-19 VACCINE ADMINISTRATION

<table>
<tr><td colspan="2"><u>Site Codes</u>: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA</td><td colspan="2"><u>MFG Codes:</u> PFR=Pfizer, MOD=Moderna, ASZ=AstraZeneca, JSN=Janssen, NVX=Novavax, MSD=Merck</td><td></td></tr>
<tr><th>Route</th><th>Site Code</th><th>Dosage mL</th><th>MFG Code</th><th>Lot Number</th></tr>
<tr><td>☐ IM</td><td></td><td></td><td></td><td></td></tr>
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Signature of Vaccine Administrator: ____**Title**__________________**Date**_____________________