COVID-19 Screening and Consent Form

Please Print

Section 1: Vaccine Recipient Information

Today's Date: _____

Name: _____

Address: _____
Street City State Zip

Date of Birth: _____ Phone number: _____

Race

☐ American Indian or Alaskan Native
☐ Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Black or African American
☐ White
☐ Other Race

Ethnicity

☐ Not Hispanic or Latino
☐ Hispanic or Latino

Primary Language

☐ English
☐ Spanish

Administered at: _____

Section 2: Screening Questionnaire

Are you feeling sick today?	**YES** ☐	**NO** ☐
Have you been treated with antibody therapy for COVID-19 in the past 90 days?	**YES** ☐	**NO** ☐
Have you had a serious or life-threatening allergic reaction, Such as such as hives, or difficulty breathing to *any* vaccine or shot?	**YES** ☐	**NO** ☐
Have you had any vaccines in the past 14 days? (Including flu shot)	**YES** ☐	**NO** ☐
Are you pregnant, considering becoming pregnant or breast feeding?	**YES** ☐	**NO** ☐
Do you have cancer, leukemia, HIV/AIDS, history of autoimmune disease or any other conditions that weakens the immune system?	**YES** ☐	**NO** ☐
Do you take any medications that affect your immune system such as steroids, anticancer drugs, or have you had any radiation treatments?	**YES** ☐	**NO** ☐

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or licensed vaccine. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Consent

I have received, read, or had explained to me, and understand the COVID-19 vaccine information sheet provided. I hereby authorize ____Wellness 2000, Inc._____ to administer the vaccine I have requested as a two-dose series __28___ days apart. The scope of this consent includes administration of the vaccine, discussion with a provider if requested, care and treatments immediately after administration as needed.

_____ _____

Signature Date

Section 3: To be completed by vaccinator

Administrator: _____

Vaccine Administered Brand: _____ Lot #: _____	First Dose ☐	Second Dose ☐
Administration Site:	L Deltoid ☐	R Deltoid ☐

TRIMET

Wellness2000, Inc.
Corporate Wellness • Health Risk Management • Employee Assistance