COVID-19 VACCINE SCREENING AND CONSENT FORM

SECTION 1: INFORMATION ABOUT YOU

LAST NAME

FIRST NAME

MIDDLE NAME

DATE OF BIRTH (Month/Day/Year)

AGE IN YEARS:

SEX (Gender assigned at birth)

○ Male ○ Female

ETHNICITY

○ Hispanic or Latino
○ Not Hispanic or Latino
○ Unknown

RACE

○ American Indian or Alaska Native ○ Asian ○ Black or African American
○ Native Hawaiian or Other ○ Pacific Islander ○ White ○ Other Asian ○ Other Nonwhite
○ Other Pacific Islander

STREET ADDRESS

CITY

STATE

ZIP CODE

Email: ____

Cell-Phone number: ____

IS THIS THE PATIENT'S FIRST OR SECOND DOSE OF COVID-19 VACCINATION?

○ First Dose ○ Second Dose

Is the Patient age 65 or older or Medicare Eligible?

○ Yes ○ No

Medicare Part A/B ID Number (MBI).

NOTE: MBI is required for all patients age 65 and older, or Medicare eligible. Refer to your Medicare Red, White, and Blue card.

Medical Insurance Provider

Cardholder / Certificate / Beneficiary ID number

Effective Date

Is the patient the primary cardholder?

○ Yes ○ No

If No, Include the primary cardholder's date of birth (month/day/year)

IF UNINSURED, YOU MUST CHECK THE BOX BELOW TO ATTEST THAT THE FOLLOWING INFORMATION 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. In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, please provide either (a) a valid Social Security number, (b) state identification number and state of issuance, OR (c) a driver's license number and the state of issuance.

Social Security Number

or State Identification Number & Issuing State

or Driver's License Number & State

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SECTION 2: COVID-19 SCREENING QUESTIONS – Please check YES or NO for each question

Are you sick today?
◯ Yes ◯ No

Have you had a severe allergic reaction to a previous dose of vaccine or to any of the ingredients of this vaccine?
◯ Yes ◯ No

Do you carry an Epi-pen for emergency treatment of anaphylaxis?
◯ Yes ◯ No

For Women: Are you pregnant or is there a chance you could become pregnant?
◯ Yes ◯ No

For Women: Are you breastfeeding?
◯ Yes ◯ No

Have you had any other vaccinations in the previous 14 days?
◯ Yes ◯ No

In the past two weeks, have you tested positive for COVID-19?
◯ Yes ◯ No

Have you had, in the past 10 days, fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?
◯ Yes ◯ No

Do you have allergies or reactions to any medications, foods, vaccines, or latex?
◯ Yes ◯ No

If Yes, please explain: ____

Are you immunocompromised or on a medicine that affects your immune system?
◯ Yes ◯ No

If Yes, please explain: ____

Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?
◯ Yes ◯ No

If Yes, please explain: ____

Have you received a previous dose of any COVID-19 vaccine?
◯ Yes ◯ No

If Yes, which manufacture's vaccine did you receive: ____

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SECTION 3: Informed Consent

COVID-19 Informed Consent:

1. I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the patient and confirm that the patient is at least 18 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to OMNI Healthcare, Inc., or its agents to administer the COVID-19 vaccine.
2. I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under the EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
3. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
4. I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
5. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the State of Florida, OMNI Healthcare, Inc., and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with , or in any way related to the administration of the vaccine listed above.
6. I acknowledge that: (a) I understand the purposes/benefits of Florida SHOTS, Florida's immunization registry and (b) OMNI Healthcare, Inc., will include my personal immunization information in Florida SHOTS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
7. I further authorize OMNI Healthcare, Inc., or it's agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to OMNI Healthcare, Inc., or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if OMNI Healthcare, Inc., invoices me after the time of service, upon receipt of such invoice.
8. I acknowledge receipt of the Notice of Privacy Rights.

____ __________________

Signature of Patient or Authorized Representative Date

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Print Name of Representative and Relationship to person receiving vaccine