OZARKS COMMUNITY HEALTH CENTER
COVID-19 Vaccination Consent under Emergency Use Authorization

PATIENT DEMOGRAPHIC INFORMATION

*Last Name:	*First Name:	Middle Initial:	
*Date of Birth / /	*Sex: Male ☐ Female ☐ Transgendered ☐ Other ☐		
*Race White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan Native ☐ None Specified ☐ Refused ☐		Hispanic Ethnicity: Yes ☐ No ☐ Unknown ☐ Refused ☐	
Address:		City:	
State: Zip:	Home Phone:	Cell Phone:	
Email:	Would like a reminder for the next appointment Yes ☐ or No ☐ postcard/call/text		
Private or employer insurance ☐	Underinsured ☐	Uninsured ☐	Medicaid ☐

HEALTH HISTORY	YES	NO	UNKOWN
1. Are you feeling moderately or severely ill today? (mild illness or taking antibiotics are not reasons to withhold the vaccine)	☐	☐	☐
2. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or Epi Pen or for which you had to go to the hospital? If yes please list _____	☐	☐	☐
3. Have you ever had a serious reaction after any vaccination or injectable medication including a previous dose of the COVID-19 vaccine?	☐	☐	☐
4. In the past 14 days have you had: - Contact with a confirmed COVID-19 patient? - Tested positive for Covid? - Received any vaccine (flu, pneumonia, shingles etc…)	☐	☐	☐
5. Are you breastfeeding or pregnant, or planning on becoming pregnant in the next 6 months?	☐	☐	☐
6. Have you received Bamlanivimab monoclonal antibody therapy or convalescent plasma as a treatment for COVID-19 in the last 90 days?	☐	☐	☐
7. Are you immunocompromised? (Have you taken medications in the past 3 months that affect your immune system, such as , prnidone,other steroids,anticancer drugs, drugs for rheumatoid arthritis, Crohn's disease or psoriasis,or have you had radiation treatments?	☐	☐	☐
8. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
9. In the past year, have you received a dose of Covid 19 vaccine? If yes, date of dose: _____ Manufacturer_____	☐	☐	
10. Do you currently have or have a history of a neurological condition, seizures, or have ever had Guillain-Barre` syndrome?	☐	☐	☐

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICP to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The CICP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use of covered countermeasures identified in a PREP Act declaration. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV–2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any such product. Information about the CICP and filing a claim is available by calling 1-855-266-2427 or visiting http://www.hrsa.gov/cicp/.

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PLEASE PRINT NAME of signature below		
SIGNATURE OF PATIENT	**RELATIONSHIP TO CLIENT**	**TODAY'S DATE**
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES I, _____, acknowledge and agree that I have received or have been advised of the Missouri Department of Health and Senior Services' Notice of Privacy Practices and where I can obtain any revisions made to this Notice. *Print NAME HERE*		
Client Signature/Legal Representative	***Relationship to Client***	***Today's Date***

For Clinic Use only

Manufacturer	**Brand**	**Lot number**
Dose number 1☐ or 2☐	***Exp. Date**: ___ /___ /___	***Date Administered**: ____ /____ /___
***EUA fact sheet date: ___ /___ /___**	***** EUA fact sheet given date: ___ /___ /___**	**Injection Site (Deltoid) L ☐ R ☐**
***Administered by Name & Title :**		
***Agency:OZARKS COMMUNITY HEALTH CENTER**		
***Clinic administration address 18614 JACKSON STREET,HERMITAGE ,MO 65668**		