Ellenton Urgent Care
A Smart ER Alternative

COVID-19 VACCINE SCREENING AND CONSENT FORM

Name: Last:	First:
Date of Birth:	

Patient's first or second dose of the COVID-19 vaccination First Dose Second Dose

COVID-19 SCREENING QUESTIONS

Please check Yes or No for each question	**Yes**	**No**
1.Do you have today, or have you had at any time in the last 10 days a 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?		
2.Have you tested positive for and/or been diagnosed with COVID-19 infection within the last 10 days?		
3.Have you had a severe allergic reaction (e.g. needed epinephrine or hospital care) to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
4.Have you had any other vaccinations in the last 14 days (e.g. influenza vaccine, etc.)?		
5.Have you had any COVID-19 antibody therapy within the last 90 days (e.g. Regeneron, Bamlanivimab, COVID Convalescent Plasma, etc.)		

IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE

Please check Yes or No for each question	**Yes**	**No**
6.Do you carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies to any medications, foods, vaccines, or latex?		
7.For women, are you pregnant or is there a change you could become pregnant?		
8.For women, are you currently breastfeeding?		
9.Are you immunocompromised or on a medication that affects your immune system?		
10. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
11.Have you received a previous doe of any COVID-19 vaccine? If yes, which manufacture's vaccine did you receive:		

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age; or (c) legally authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to t Venture Medical of Florida or its agents to administer the COVID-19 vaccine.

I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals either 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.

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.

I acknowledge that I have been advised to remain near the vaccination location for approximately 15/30 minutes (or more in specific cases) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.

On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Venture Medical of Florida 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.

I acknowledge that: (a) I understand the purposes/benefits of Florida SHOTS, Florida's immunization registry and (b) Venture Medical of Florida 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.

I further authorize Venture Medical of Florida 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 Venture Medical of Florida 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 Venture Medical of Florida invoices me after the time of service, upon receipt of such invoice.

Signature of Patient or Authorized Representative _____ Date: _____
Print Name of Representative and Relationship to Person Receiving Vaccine: _____

_____

Site	Route	Manufacturer	Lot #	Expiration Date	Date of EUA Fact Sheet
LD/RD	IM				

Vaccinator Print Name: _____ Date: _____

Vaccinator Signature: _____

Time vaccine administered: _____ 15/30 minutes checkup time: _____

Swelling face or throat
Fast heartbeat
Rash
Dizziness and weakness
Shortness of Breath
Change in Vision
Feeling Confused
Nauseous

Patient oriented without complaints, concerns at discharge