Immunization Consent and Release Form

Section 1: PATIENT INFORMATION			
Last Name:	First Name:	Date of Birth:	Gender: M /F
Street Address:	City:	State:	Zip Code:
Email Address:	Mobile Phone Number:	SSN:	
Allergies/Health Conditions:			
Race: ☐ White ☐ Hispanic/Latino ☐ Black/African American ☐ Native American/Alaska Native ☐ Asian Native Hawaiian/Other Pacific Islander ☐ Other			

Section 2: CONSENT & RELEASE

- I understand the benefits and risks of vaccination as described in the Emergency Use Authorization (EUA) Fact Sheet and/or CDC Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release.
- I request the vaccine be given to me or the person named below, a minor for whom I represent that I am authorized to sign this Consent and Release.
- I understand that information about this vaccination will be included in Michigan Care Improvement Registry Immunization Information System.
- I agree to remain at the vaccination location for 15 minutes after vaccination for observation for adverse events.
- I authorize the release of any medical information necessary to process my insurance claim(s), request payment of medical benefits directly to this provider, and that the authorization covers all related medical services rendered.

*My signature below indicates I have read, understood, and agreed to **Section 2: Consent and Release** of the Immunization Consent Form and Emergency Use of Authorization Fact Sheet (EUA).*

Signature of Person to Receive Vaccine (Parent/Guardian if a minor, please print name as well):

X:_____ Date:_____

Section 3: PHARMACY DOCUMENTATION (filled out by vaccinator/staff)

Vaccine/MFR	Date Administered	Lot #	Expiration Date	Dosage	Injection Site	Dose Number	Billing/MCIR
					☐ Left Arm ☐ Right Arm	☐ First ☐ Second	☐ Billing ☐ MCIR

Administering Immunizer Signature: _____ **Title:** _____

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name _____

Age _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product _____			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of a COVID-19 vaccine including either of the following:			
○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
• A previous dose of COVID-19 vaccine.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Form reviewed by _____ **Date** _____