CAR LICENSE PLATE#

CITY OF PASSAIC DIVISION OF HEALTH

330 Passaic St., Passaic, NJ 07055
Phone: 973-365-5656

COVID-19 VACCINE SCREENING AND CONSENT FORM

Last Name	First Name	Date of Birth	Age	Gender (M / F)

Phone Number	E-Mail	Birth Country

Address	City	County	State	Zip

Primary Care Provider (PCP) Name	PCP Address	PCP Phone

Guardian/ Surrogate/P.O.A. (if applicable, please print)	Phone	Preferred Language

Ethnicity _____

Ethnicity Key:
DECL – Declined **HIS** – Hispanic Origin
NHL – Non-Hispanic Origin
UNK – Unknown

Race _____

Race Key:
AIA – Native American or Alaskan ASN – Asian
BAA – African American or Black DECL–Declined
NHP – Native Hawaiian or Pacific Islander
WHT – White **OTH** – Other or Multiracial

	POTENTIAL CONTRAINDICATIONS			
1.	Are you feeling sick today? (Fever, Respiratory Infection, or other moderate/severe illness)	□ Yes	□ No	
2.	Have you tested positive for COVID-19 in the past 14 days (2 weeks)?	□ Yes	□ No	
3.	In the last 10 days, have been told by a healthcare provider or health department to isolate or quarantine for COVID-19 infection or exposure?	□ Yes	□ No	
4.	Have you received antibody therapy (monoclonal antibodies or convalescent plasma) for COVID-19 in the past 90 days (3 months)?	□ Yes	□ No	
5.	Have you had any vaccines in the past 14 days (2 weeks) including flu shot?	□ Yes	□ No	
6.	Have you ever had a serious or life-threatening allergic reaction (e.g., anaphylaxis), such as hives or difficulty breathing, to any COVID-19 vaccine or any component of the vaccine, including mRNA, lipid nanoparticles or polyethylene glycol (PEG)?	□ Yes	□ No	
7.	Are you under 18 years of age?	□ Yes	□ No	
	POTENTIAL CONSIDERATIONS			
1.	Have you ever had a serious or life-threatening allergic reaction (e.g., anaphylaxis), such as hives or difficulty breathing, to any vaccine or shot/injection?	□ Yes	□ No	
2.	Have you ever had a serious or life-threatening allergic reaction (e.g., anaphylaxis), such as hives or difficulty breathing, due to any cause? (Including medications, foods, latex, or any item.)	□ Yes	□ No	
3.	Are you currently pregnant?	□ Yes	□ No	□ Unknown
4.	Are you currently breastfeeding?			
5.	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	□ Yes	□ No	
6.	Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer or rheumatologic drugs, or have you had any radiation treatments?	□ Yes	□ No	
7.	Do you have a bleeding disorder or taking any blood thinner or anticoagulants?	□ Yes	□ No	
8.	Have you received a prior dose of COVID-19 Vaccine? If so, provide date.	□ Yes	□ No	Date:_____

CAR LICENSE PLATE#

CITY OF PASSAIC DIVISION OF HEALTH

330 Passaic St., Passaic, NJ 07055
Phone: 973-365-5656

Last Name:_____ First Name: _____ Date of Birth_____

CONSENT FOR VACCINATION

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. 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 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. 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.

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

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet(s) or patient fact sheet corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. If the recipient has previously had a severe allergic reaction in the past for any reason, I agree to wait near the clinic location for 30 minutes after receiving the vaccine in designated area. I understand if I experience side effects that I should do the following: contact doctor, call 911, or go to hospital. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

I acknowledge that I have received and viewed the Vaccine Information Statement or Emergency Use Authorization Information Sheet and Passaic Division of Health Notice of Privacy Practices. I will/have reviewed my answers to the questions above with the vaccinator. I understand that the COVID-19 vaccine is a two-part vaccine series. By signing this consent, I am agreeing that I will receive the first and second part of the vaccine series, and understand the second dose may be required to be effective.

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccine. I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent).

AUTHORIZATION TO REQUEST PAYMENT: I understand there will be no cost to me for this vaccine. I do hereby authorize City of Passaic Health Division and/or its agents to release information, submit a claim, and request payment. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider. I certify that the information given by me in applying for payment under my insurance provider, Medicare or Medicaid, other third parties who are financially responsible for my care, or the HRSA COVID-19 Program for Uninsured Patients, are correct. I authorize release of all records to act on this request. I assign and request that payment of authorized benefits be made on my behalf to City of Passaic Division of Health or its agents with respect to the above requested items and services.

DISCLOSURE OF RECORDS: I understand that City of Passaic Division of Health may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at City of Passaic Division of Health Vaccination Sites (if applicable), the City of Passaic Division of Health and its agents, my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that City of Passaic Division of Health will use and disclose my health information as set forth in the City of Passaic Health Division Notice of Privacy Practices (copy is available at the City of Passaic Health Division). Vaccine Clinics: If I am receiving a vaccine through a vaccine clinic, I understand that my name, vaccine appointment date and time will be provided to the clinic coordinator.

On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the State of New Jersey, the City of Passaic Division of Health, 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/herein.

_____

Patient/Surrogate/Guardian/Power of Attorney (Signature) Date / Time **Print: Relationship to patient**

_____

Telephonic Interpreter's ID # **Date / Time**
OR

_____

Signature: Patient's Interpreter **Date/ Time** **Print: Interpreter's Name and Relationship**

CAR LICENSE PLATE#

CITY OF PASSAIC DIVISION OF HEALTH

330 Passaic St., Passaic, NJ 07055
Phone: 973-365-5656

Last Name: _____ First Name: _____ Date of Birth _____

(BELOW FOR CLINIC USE ONLY)
Administration Facility Name/Facility ID: City of Passaic Health Division #16ADO7

NJIIS #_____

Nursing Vaccine Administration Information				
Vaccine Manufacturer	**Administration**	**EUA Fact Sheet Date**	**Lot Number**	**Expiration Date**
	☐ **First Dose** ☐ **Second Dose**			

Dose: 0.5mL	**Route: IM**		
Administration Site:	☐ **Left Deltoid**	☐ **Right Deltoid**	☐ **Other**

☐ All screening questions have been reviewed and discussed.

☐ I have reviewed side effects with patient (and guardian or surrogate or POA, as applicable)

☐ I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered correctly and to the best of my ability, as well as providing resources relating to this product.

Vaccinator Signature/Date: _____

Vaccinator Printed Name: _____

CITY OF PASSAIC
DIVISON OF HEALTH

PATIENT ATTESTATION FOR NO INSURANCE
PATIENT ATTESTATION FOR NO IDENTIFICATION
COVID-19 VACCINATION

Please print all information clearly

☐ **NO INSURANCE**

I, _____, attest that I am uninsured effective as of _____/_____/_____.

☐ **NO IDENTIFICATION**

I, _____, attest that I am unable to provide identification because_____.

Date of Birth (mm/dd/yyyy): _____/_____/_____

Home Address: _____

Apt. _____

City, State _____

Zip Code _____

Home Number: _____

Cell Number: _____

I affirm that all information given on this attestation is true, complete, and accurate to the best of my knowledge.

Signed (patient): _____ Date: _____/_____/_____

Witnessed: _____ Date: _____/_____/____