2021 COVID-19 Consent & Screening Form

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information.

Information about the person to receive vaccine (please print): *Required Fields

Name: (Last, First, MI)*	Date of birth: * _____ _____ _____ Month Day Year	Age*	Sex: (Circle)* Male Female
Street Address:*			

City:*	State: *	Zip:*	Phone:* ( )

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

Race:
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African-American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Race
- ☐ Unknown/Undetermined
- ☐ White

Insurance Information: *Include the whole member ID number and any letters that are part of that number*

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)
Medicare Number:	Is Medicare Primary? Yes No	Is Subscriber Retired? Yes No

Insurance subscriber/policy holder, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * _____ _____ _____ Month Day Year	Sex: (Circle)* Male Female
Subscriber's Street Address:* (If different from address above)		

City:*	State:*	Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (Circle)* Spouse Child Other			

I have been given a copy and have read and/or had explained to me the 2021 COVID Vaccine Fact Sheet and understand the risks/benefits. I give permission for vaccine administration, for my insurance company to be billed and entry/sharing of this information in the Massachusetts Immunization Information System (MIIS).

#1) ____ Date: ________________

(Signature of patient, parent or legal guardian)

#2) ____ Date: ________________

(Signature of patient, parent or legal guardian)

Provider (Check)	Provider Name/Address	Provider PIN #:
	Town of Grafton, Board of Health, 30 Providence Road, Grafton, MA 01519	14900
	Town of Holden, Board of Health, 1196 Main Street, Town Hall, Holden, MA 01520	22556
	Town of Shrewsbury, Board of Health, 100 Maple Avenue, Shrewsbury, MA 01545	11542
X	City of Worcester, Division of Public Health, 25 Meade Street, Room 200, Worcester, MA 01610	11816

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	SCREENING QUESTION (Please complete before clinic. Information will be reviewed by vaccinator.)	YES	NO
1	Do you have specific questions regarding receipt of COVID-19 Vaccine?		
2	Are you currently sick, feel ill, or have a fever over 100°F?		
3	Have you received a COVID-19 vaccine before? If so, which one________________ Date___________________		
4	Have you had an adverse or allergic reaction to a prior COVID-19 vaccine, or allergic reaction to any other vaccine or injectable therapy?		
5	Do you have hemophilia or other bleeding disorder or take a blood thinner?		
6	Do you have an immunocompromising condition (HIV/AIDS, cancer, leukemia, etc) or take an immunocompromising medicine or treatment (steroids, chemotherapy, radiation therapy, etc)?		
7	Are you, or might you be, pregnant or are you nursing (breastfeeding)?		
8	Have you received another vaccine within the past 14 days? If yes, you cannot get COVID vaccine today.		
9	Were you ever diagnosed with COVID 19? If yes, are you recovered? Did you receive monoclonal antibodies or convalescent plasma as treatment? If yes, please wait 90 days from treatment date to get vaccine.		

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For Clinic/Office Use Only

Date of Service	Vax Type	Vaccine Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied	Preserv Free	Injection Route	Injection Site (Circle)	Date On FAQ	Date FAQ Given
#1	COVID19	J&J			0.5	Yes	Yes	IM	R Arm L Arm	03/19/2021	
#1	COVID19	Moderna Pfizer			0.5 0.3	Yes	Yes	IM	R Arm L Arm	03/26/2021 02/25/2021	
#2	COVID19	Moderna Pfizer			0.5 0.3	Yes	Yes	IM	R Arm L Arm	03/26/2021 02/25/2021	

Dose #1) Signature of Vaccine Administrator:

____

Dose #2) Signature of Vaccine Administrator:

____

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