Seven Hills Behavioral Health

Vaccine Administration Record- Informed Consent for Vaccination
(For use with COVID-19 Vaccine Administration Clinic)

For office use only:
1st _____
2nd _____
3rd _____

Patient Information

Name:_____ **Date of Birth**:___/___/___

Address: _____ STREET CITY ZIPCODE

Phone Number:_____ **Email Address**:_____

Gender Identity: ☐Male ☐Female ☐Transgender ☐Nonbinary ☐Questioning ☐Other

Sexual Identity: ☐Straight or Heterosexual ☐Gay or Lesbian ☐Bisexual and/or Pansexual ☐Other

Primary Language:_____ **Country of Birth**:_____

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐Black/African American ☐ White
☐Other ☐Native Hawaiian/Pacific Islander ☐Don't Know

Hispanic/Latinx: ☐Yes ☐No ☐Don't Know

Insurance: ☐Masshealth ☐Medicare ☐Health Safety Net ☐Private ☐Other ☐No Insurance

Do you have a Primary Care Provider: ☐ Yes ☐ No ☐ Don't Know

I want to receive the following vaccination(s): ☒Moderna ☐Janssen ☐Pfizer

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; (c) the legal guardian of the patient.

1. I certify that the information I have provided is correct and that I have the legal authority to give consent for me and any other person(s) I registered to be vaccinated with the vaccine(s) above.
2. I hereby give my consent to Seven Hills Behavioral Health, the Seven Hills Behavioral Health staff, New Bedford Emergency Medical Services, and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable provider"), to administer the vaccine(s) I have requested above.
3. 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 Fact Sheet for Recipients and Caregivers" on the vaccine(s) 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.
4. I acknowledge that I have been advised to remain near the vaccination location for observation for approximately 15 minutes after administration.

5. On behalf of myself, my heirs and personal representatives, I hereby release and hold 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(s) listed above.
6. I give permission for my insurance company to be billed for the costs of administering the vaccine(s). The government is paying for the vaccine itself and I will not be billed for that portion of the cost of my immunization.
7. I understand that, as required by state law, all immunizations will be reported to the Department of Public Health Massachusetts Immunization Information System (MIIS). MIIS is a confidential, web-based system that collects and stores vaccination (shot) records accessible to healthcare providers and local boards of health. I consent to having my vaccination information entered into MIIS. I understand I may access the MIIS factsheet for Parents and Patients, at **www.mass.gov/dph/miis**, for information on the MIIS and what to do if I object to my or my family's data being shared with other providers in the MIIS.

Patient Signature: _____ **Date:** _____

(Parent or guardian, if minor)

For clinic/office use only:

1st dose:

Date of Service	Vaccine Type	Vaccine Mfgr	Lot #	Mfgr Date	Dose (ml)	State Supplied	Injection Route	Injection Site	Date EUA given
	COVID-19					MA	IM	R arm L arm	

Signature of Vaccine Administrator: _____ **Date:** _____

2nd dose:

Date of Service	Vaccine Type	Vaccine Mfgr	Lot #	Mfgr Date	Dose (ml)	State Supplied	Injection Route	Injection Site	Date EUA given
	COVID-19					MA	IM	R arm L arm	

Signature of Vaccine Administrator: _____ **Date:** _____

3rd dose:

Date of Service	Vaccine Type	Vaccine Mfgr	Lot #	Mfgr Date	Dose (ml)	State Supplied	Injection Route	Injection Site	Date EUA given
	COVID-19					MA	IM	R arm L arm	

Signature of Vaccine Administrator: _____ **Date:** _____

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:			
o Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
o 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** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists