# Duxlink Health

## COVID-19 Vaccine Screening and Consent Form

Last Name: _____ First Name:_____

Date of Birth: _____ Age: _____ Gender (circle one): Male / Female

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ (home); _____ (work); _____(mobile)

Emergency Contact: _____; Telephone: _____

Primary physician: _____; Telephone: _____

Primary Insurance Carrier ID #: _____ Group ID#: _____

Insurance Company : _____ Insurance Company Phone # _____

Insured's Name: _____ Relationship: _____ Insured's Date of Birth: _____

***Screening Questions (if you answer yes, please explain below) Please circle**

Is this the patient's first or second dose of the COVID-19 vaccination? ☐ First Dose ☐ Second Dose

| | | |
|---|---|---|
| 1. Are you sick today or have you had an illness in the last 30 days or a COVID diagnosis in the last 90 days or have you received convalescent plasma? | Yes | No |
| 2. Do you have allergies to medications, food, a vaccine component, or latex? | Yes | No |
| 3. Have you ever had a serious reaction after receiving a vaccination? | Yes | No |
| 4. Do you have a long-term health problem with anemia, low platelets or other blood disorder, or have you had a problem with an IM injection. | Yes | No |
| 5. Do you have cancer, leukemia, AIDS, or any other immune system disorder? | Yes | No |
| 6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? | Yes | No |
| 7. Have you had Guillain Barre Syndrome? | Yes | No |
| 8. **For women:** Are you pregnant/breastfeeding or is there a chance you could become pregnant during the next 3 months? | Yes | No |
| 9. Have you received any vaccinations in the past 4 weeks? | Yes | No |

**IMPORTANT – Centers for Disease Control (CDC) Risk Factor Questions – Do you have any of the below conditions?**

| | | |
|---|---|---|
| Are You Home Bound? | Yes | No |
| Have you been Hospitalized in the last 12 Months? If yes, How many Times_____ | Yes | No |
| Diabetes mellitus | Yes | No |
| Hypertension or high blood pressure | Yes | No |
| Obesity (body mass index [BMI] of 30 kg/m2 or higher | Yes | No |
| Pregnancy | Yes | No |
| Cancer | Yes | No |
| Chronic kidney disease | Yes | No |
| COPD (chronic obstructive pulmonary disease) or Asthma (moderate-to-severe) | Yes | No |
| Cystic fibrosis | Yes | No |
| Pulmonary fibrosis (having damaged or scarred lung tissues) | Yes | No |
| Smoking | Yes | No |
| Any Heart conditions | Yes | No |
| Cerebrovascular disease | Yes | No |
| Neurologic conditions, such as dementia | Yes | No |
| Down Syndrome | Yes | No |
| Weakened immune system | Yes | No |
| Liver disease | Yes | No |
| Any Blood Disorders | Yes | No |
| Sickle cell disease | Yes | No |

**If you answered "Yes" to any of the foregoing questions, please explain:**

_____

_____

**I hereby acknowledge the following:**

_____ I understand that I am not required to receive the Vaccine; however, I have voluntarily chosen to receive the Vaccine and accept all known and potential risks related to receiving the Vaccine.

_____ I have been provided with a copy of, and reviewed the contents of, the attached Vaccine Information Sheet (VIS) or Emergency Use Authorization (EUA)

_____ The undersigned Provider Representative has explained to me, and I understand that:

_____ Known potential adverse reactions to the Vaccine include each of the potential adverse reactions identified in the VIS or EUA provided to me.

_____ There may be additional adverse reactions to the Vaccine that are not identified in the VIS or EUA provided to me.

_____ I have had the opportunity to ask questions concerning the Vaccine, the administration of the Vaccine and potential adverse health consequences of receiving the Vaccine, and all of my questions have been answered to my satisfaction.

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

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

_____If Necessary, I further authorize Duxlink Health or its agents 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 Duxlink Health or its agents 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 Duxlink Health invoices me after the time of service, upon receipt of such invoice.

_____ I have provided full and truthful information for the completion of this Consent Form.

**Consent and waiver:** I consent to the administration of the Vaccine by representatives of Duxlink Health. I fully release and discharge Duxlink Health, its affiliates and their officers, directors, employees and persons acting on their behalf or at their direction from any liability or claim related to the administration of, or my receipt of, the Vaccine.

Signature of patient or Legal Guardian:_____Date:_____

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**To be completed by Duxlink Health representative**

Medication:_____ VIS/EUA Date: _____ Lot #:_____ Exp Date: _____ Site: ____

Medication:_____ VIS/EUA Date: _____ Lot #:_____ Exp Date: _____ Site: ____

Administered by: _____ Title: _____ Date Given:_____

***Based on Florida Department of Health COVID Vaccine Screening and Consent Questions.** Duxlink Health COVID Vaccine Screening and Consent Form Version 7. Date 1-22-21