

COVID-19 VACCINE SCREENING AND CONSENT FORM

Administration Facility Name/Facility ID:

Name: Last:		First:		Midd	lle Initial:		
Date of Birth: Month	Day	Year	Year Mobile Phone Number (Patient or Guardian): (
Address:				Apt/Rooi	m #:		
City:		;	State: Zip:				
Name of Legal Guardian: Last:			First: Middle Initial:				
Sex (Gender assigned at birth) ☐ Female ☐ Male	☐ Asian ☐ Black or	n Indian or Alaska Native	☐ Native Hawaiian or other☐ Pacific Islander☐ White	☐ Other Asian ☐ Other Nonwhite ☐ Other Pacific Isla	white □ Not Hispanic or □ Unknown		
Primary Insurance Carrier	ID #:		Grp #:				
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• I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 12 years of age (for Pfizer vaccine consent only); or (c) legally authorized to consent for vaccination for the patient named above. Further, I hereby give my consent

Page 1 of 2 Effective Date: 5/11/2021 to the Florida Department of Health (DOH) or its agents to administer the COVID-19 vaccine.

- 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 either 12 years of age or older (Pfizer only) or 18 years of age and older (Pfizer, Moderna and Johnson and Johnson); 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.
- 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 above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask guestions and that such questions were answered to my satisfaction.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the State of Florida, the Florida Department of Health (DOH), the Florida Division of Emergency Management (FDEM) 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.
- I acknowledge that: (a) I understand the purposes/benefits of Florida SHOTS, Florida's immunization registry and (b) DOH 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.
- I further authorize DOH, FDEM, 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 DOH, FDEM, 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 DOH invoices me after the time of service, upon receipt of such invoice.
- I acknowledge receipt of the DOH Notice of Privacy Practices.

Signature of P	Patient or A	Authorized Represent	Date:				
Print Name of	Represen	tative and Relationsh	ip to Person Rece	iving Vaccine:			
Site (LD/RD)	Route	Manufact	Manufacturer (MVX)		Expiration Date	Date of EUA Fact Sheet	
	IM						
				1		1	
Administer name/ID	red at lo	ocation: facility					
Administe	red at lo	cation: Type					
Administro	ıtion Ad	dress:					
CVX (prod	luct)						
Sending o	rganiza	tion:					
Vaccinator Print Name:			Signature:		Date:		
Vaccine admi	nistering p	provider suffix:			_		

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