AVENUE360 HEALTH + WELLNESS

Consent and Screening Form for COVID-19 Vaccine

Patient Name: _____ **DOB:** _____ **Employee:** □ **yes**

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone: _____ **(**□ cell □ home □ other) **Email:** _____

Race	□American Indian or Alaska Native □Asian □Black or African American □Native Hawaiian or Other □Pacific Islander □White □Other Asian □Other Nonwhite □Other Pacific Islander □Other	**Ethnicity**	□ Hispanic or Latino □Not Hispanic or Latino □Unknown

Allergies:_____

You should be aware of the following facts regarding the COVID-19 vaccine:

- Just like other medicines, this vaccine is not completely effective and can take a few weeks for your body to build up protection. There is always a chance you may still get infected by the Coronavirus even with the vaccine, so still take precautions like wearing a mask, staying 6 feet apart and avoid crowds.
- You are being offered the MODERNA Covid-19 vaccine and it REQUIRES two (2) doses, 28 days apart, to reduce your chances of being infected by Covid-19. If you only take one (1) dose, it is not effective against Covid-19.
- This vaccine has some side effects, as do other vaccines and medicines, but not everyone will get them. The most likely side effects that you may experience from the vaccine are:
  - Fever
  - Pain at the injection site
  - Redness and hardness of the skin at the injection site
  - Headache
  - Muscle aches or pain
  - Joint aches or pain
  - Fatigue (tiredness)
  - Nausea or vomiting
  - Chills
  - Underarm gland swelling on the side of the vaccination site
- If you think you are experiencing any side effects, please remain calm and contact your doctor/provider immediately. If you experience a severe reaction, call 9-1-1, or go to the nearest hospital.

Medical History:

Questions	Yes	No	Don't Know
Do you have allergies to latex, food, medications, or vaccine components? Such as eggs, thimerosal, gelatin, neomycin, phenol, bovine protein?			
Have you ever experienced a serious reaction after getting a vaccine?			
In the past year, did you receive a transfusion of blood or blood products, or get injected immune (gamma) globulin or any antiviral drug?			
Did you have any brain or other nervous system problems in the past year?			

Have you gotten vaccinated in the last 4 weeks?			
Are you pregnant or planning to get pregnant?			
Are you breastfeeding?			
Are you sick today?			
In the past two (2) weeks have you tested positive for Covid-19?			
Have you had, in the last 10 days: fever, chills, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headaches, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting or diarrhea?			
Are you immunocompromised or on a medicine that affects your immune system?			
Do you have a bleeding disorder or are you on blood thinner medication?			
If you have received a previous dose of any Covid-19 vaccine, indicate which Moderna or Pfizer.	**Moderna** □ **Pfizer** □		

CONSENT:

- I certify I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the patient and confirm that the patient is at least 16 years of age; or (c) authorized to consent for vaccination for the patient named above.
- Further, I hereby give my consent to Houston Area Community Services, Inc. d/b/a Avenue 360 Health and Wellness (Avenue360) or its agents to administer the MODERNA COVID-19 vaccine.
- I understand that this product has been authorized for emergency use by FDA, under an Emergency Use Authorization Act (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 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 **1)** Emergency Use Authorization Fact Sheet on the MODERNA COVID-19 vaccine I am receiving and the **2)** V-Safe Information. I also acknowledge that I have had a chance to ask questions 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 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 Houston Area Community Services, Inc. d/b/a Avenue 360 Health and Wellness (Avenue360), 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 Texas's immunization registry and (b) Avenue360 will include my personal immunization information in this registry and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize Avenue360 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 Avenue 360 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 Avenue 360 invoices me after the time of service, upon receipt of such invoice.
- I acknowledge receipt of the Notice of Privacy Rights.

By signing this form,

I hereby state, I have read and understood this form. I declare the above information is true and correct. I hereby give my full consent to get the COVID-19 vaccine.

Signature of Patient or Authorized Representative: _____ Date: _____

Print Name of Representative and Relationship to Person Receiving Vaccine:_____

For Internal Use Only:

1. **Name of Medication Used**: _____

Lot #:_____ EXP:_____ NDC #:_____

2. **Administration:** Administered at Ave360 Location: _____

Patient Number: _____

Patients: □ First or □ Second Dose

Administered: □ Right or □ Left Arm

Administered vaccine despite yes on Med History?

Explain: _____

_____

Administered By: _____ Printed Name

Signature: _____

Date: _____