COVID-19 VACCINE DOCUMENTATION/CONSENT FORM

VACCINE CONSENT: I have been given a copy and have read, or have had this form read to me, the information in the FACT SHEET FOR RECIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA) regarding the vaccine checked below. I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request and authorize the release of immunization records for the patient below to any school, health department or other healthcare provider. This authorization is effective for one year after the date listed below. This authorization may be revoked in writing at any time as provided for in the Family First Urgent Care (C2K Health & Wellness, PLLC) Notice of Private Practices. Family First Urgent Care (C2K Health & Wellness, PLLC) may not condition treatment on the signing of this authorization. If this information is disclosed to someone who is not covered by federal privacy regulations, the information is no longer protected by the federal privacy regulations. Immunization will be entered into ImmTrac2 system.

ACKNOWLEDGEMENT OF "NOTICE" OF PRAVACY PRACTICES: I acknowledge that a copy of Family First Urgent Care's (C2K Health & Wellness, PLLC) "Notice" of Privacy Practices has been made available to me with the effective date January 1, 2021.

Family First Urgent Care (C2K Health & Wellness, PLLC) will administer the COVID-19 vaccine regardless of the vaccine recipient's ability to pay for the COVID-19 vaccine administration fees or health plan coverage status. By signing below, you agree to all information provided in the first four sections of this form.

☐ Moderna COVID-19 Vaccine

☐ Pfizer COVID-19 Vaccine ______________________________ ______________

Signature of Client/Client Representative **Date**

Relationship to Client: ☐ Self ☐ Parent ☐ Spouse ☐ Guardian

IMMUNIZATION SCREENING QUESTIONAIRE

#	Question		Answer
1.	Are you feeling sick today?		☐ Yes ☐ No
2.	Have you ever received a dose of COVID-19 vaccine?	If yes, which product? □ Pfizer □ Moderna □ Other: ______________	☐ Yes ☐ No
3.	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?		☐ Yes ☐ No
4.	• Was the severe allergic reaction after receiving a COVID-19 vaccine?		☐ Yes ☐ No
5.	• Was the severe allergic reaction after receiving another vaccine or another injectable medication?		☐ Yes ☐ No
6.	Do you have a bleeding disorder or are you taking a blood thinner?		☐ Yes ☐ No
7.	Have you received passive antibody therapy as treatment for COVID-19?		☐ Yes ☐ No
8.	Have you received any other vaccines in the past 14 days? (Influenza, MMR, etc.)		☐ Yes ☐ No

CLIENT INFORMATION

Last Name: ______________________ First Name: ______________________ Middle Initial: _______

Social Security #: ______________ Date of Birth: ______________ Mother's Maiden Name: ______________

Race: □ White □ Hispanic □ Asian □ African American □ Other: ____________ Gender: □ M □ F

Language: □ English □ Spanish□ Other: ______________________

Physical Address: ____ City: ______________

County: ______________________ State: ________ Zip Code: __________ Phone: (_____) _______ - ____________

FAMILY/GUARANTOR INFORMATION (Required if client under 18 or client is not guarantor)

Last Name: ______________________ First Name: ______________________ Middle Initial: _______

Physical Address: ____ City: ______________

County: ______________________ State: ________ Zip Code: __________ Phone: (_____) _______ - ____________

VACCINE	MVX	CVX	LOT #	EXP DATE	DOSE
□ Moderna, COVID-19 Vaccine, 100 mcg/0.5 mL	MOD	207			□ 1st Dose □ 2nd Dose

DATE	TIME	EXT	SITE	ROUTE	NOTES:
		□ Right □ Left	□ Deltoid (Preferred) □ Vastus Lateralis	Intramuscular (IM)	

____

Provider Signature Date

Family First
URGENT CARE
WE CARE FOR YOU LIKE FAMILY