PINAL COUNTY PUBLIC HEALTH

COVID-19 Vaccine Administration Consent/Record

First Name:	Last Name:
Date of Birth:	□ Male □ Female
Mailing Address:	
Phone Number:	City: State: ZIP:
Emergency Contact Name/Relationship:	Emergency Contact Phone Number:
Race: □ White □ Asian □ African American □ Native American □ Native Hawaiian/Pacific Islander	Ethnicity: □ Hispanic □ Non-Hispanic □ Unknown

Insurance Type:	*Insurance will be billed for administration fee only. If not covered by insurance, you will not be billed.
□ Medicare Part B #______________	Insurance Plan:____
□ AHCCCS	Ins. ID#:______________________Group#:______________________
□ County Employee	Insured Name:______________________Date of Birth:______________
□ Private	Relationship to Patient:______________Ins. Eligibility Phone#:______________
□ Other	Driver's License if avail#:______________Issued Date:__________State of Residence:_____
□ None	

Moderna COVID-19 Fact Sheet: https://www.fda.gov/media/144638/download,
Janssen COVID-19 Fact Sheet: https://www.fda.gov/media/146305/download

Question	Answer
Are you 18 years of age or older?	□ Yes □ No ________________
Do you have any allergies to medications? (hives, rash, swelling, etc)	□ Yes □ No ________________
Have you ever had an anaphylaxis reaction?	□ Yes □ No ________________
Have you ever had a serious adverse reaction to a prior vaccine or injectable?	□ Yes □ No ________________
Have you had a dermal filler?	□ Yes □ No ________________
Do you have any allergies to any of the Moderna vaccine ingredients that you are aware of? Please read each one carefully. *Nucleoside-modified mRNA encoding the viral spike(S) glycoprotein of SARS-CoV-2 *PEG2000-DMG: 1,2-dimyristoyl-rac-glycerol,methoxypolyethylene glycol * 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC] *SM-102: heptadecane-9-yl 8-((2-hydroxyethyl)(6-oxo-6-(undecyloxy) hexyl) amino) octanoate *Tromethamine *Tromethamine hydrochloride *Sucrose *Acetic acid *Sodium acetate *Cholesterol	□ Yes □ No ________________
Have you ever had an allergic reaction to any component of a COVID-19 vaccine, including **polyethylene glycol (PEG)**, which is found in some medications, such as laxatives and preparations for colonoscopy procedures? **Such as Polysorbate or a previous COVID-19 vaccine?**	□ Yes □ No ________________
Do you have any allergies to any of the Janssen vaccine ingredients that you are aware of? Please read each one carefully. * Recombinant, replicationincompetent Ad26 vector, encoding a stabilized variant of the SARS-CoV-2 Spike (S) protein *Polysorbate-80 2-hydroxypropyl-β-cyclodextrin *Citric acid monohydrate *Trisodium citrate dehydrate * Sodium chloride *Sodium hydroxide *Hydrochloric acid *Ethanol *Water for injection	□ Yes □ No ________________
Do you have a bleeding disorder or are you on a blood thinner?	□ Yes □ No ________________
Are you pregnant or breastfeeding? (Discuss with OB/GYN before receiving a vaccine.)	□ Yes □ No ________________
Are you ill or have a fever today?	□ Yes □ No ________________
Have you ever had a positive test for COVID-19 or told you had COVID-19?	□ Yes □ No ________________

PINAL COUNTY PUBLIC HEALTH   Name: ______________________________   DOB:______________

Have you traveled internationally in the past 14 days? (If **YES** please list where.)	□ Yes □ No ________________
Are you immunocompromised or taking a medicine that affects your immune system?	□ Yes □ No ________________
Have you had any other vaccines in the last 14 days?	□ Yes □ No ________________
Have you received another COVID-19 vaccine? ☐ Pfizer ☐ Moderna ☐ Janssen	□ Yes □ No ________________
Have you received passive antibody therapy as part of (monoclonal antibodies or convalescent plasma) as part of COVID-19 treatment in the last 90 days?	□ Yes □ No ________________

If you answered "Yes" to any of the above questions above, please be prepared to discuss this with the nurse administering your vaccine. Please read the following statements carefully and ask any questions if there is something you don't understand. <u>Please initial each line.</u>

_____I agree that I have received, reviewed and understand the Moderna and/or Janssen COVID-19 Fact Sheet depending upon which vaccine I am receiving and answered all of the screening questions on the consent. I am aware that if any serious adverse reactions result from the vaccine that I should report it to my Primary Care Provider or the health department.

_____I understand the common risks associated with the COVID-19 vaccine include redness, swelling at the site of the injection, tiredness, headache, muscle pain, chills, joint pain, and fever, nausea, feeling unwell or swollen lymph nodes (lymphadenopathy).

_____I understand that the vaccine may cause a severe allergic reaction which can include anaphylaxis (difficulty breathing, swelling of the face/throat, a fast heartbeat, rash, dizziness and or weakness). I understand that these may not be all the effects of the COVID-19 vaccine.

_____ I understand that the long term, side effects or any possible complications of this vaccine are not known at this time.

_____If I am pregnant or breastfeeding, I have consulted with my OBGYN provider who has recommended I get this vaccine.

_____I understand that the FDA has authorized use of the Moderna and Janssen Vaccines are under an Emergency Use Authorization (EUA) and that there is currently not enough scientific evidence available for the FDA to fully approve this or any other COVID-19 vaccine.

_____I understand that a second dose is required a minimum of 28 days after the first for optimal protection against the COVID-19 Virus if I am receiving the Moderna Vaccine today. This does not apply to Janssen vaccine

_____I understand it is recommended that I remain on site for at least 15 minutes after receiving the vaccine and that, depending on the recommendations of medical professionals, I may be asked to remain on site longer for monitoring

_____I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine and ask that it be given to me or to the person below for whom I am authorized to make this request. I agree to allow the release of this information to the Arizona State Immunization System (ASIIS) to record that I (or the person whom I have authorized consent) have received the COVID-19 vaccine.

Signature of Recipient (Parent or Guardian):	**Date**

Area Below to be completed by Vaccinator

VIS/Fact Sheet Date:	Moderna 12/2020 Janssen 2/2021	**Lot Number:** **Exp date:**	__________________ __________________
Manufacturer:	Moderna or Janssen	**Administration Date:**	__________________
Dosage:	0.5 mL	**Administration Site:**	□ LD □ RD
Dose#:	□ 1 □ 2	**Fact Sheet given**	□
Vaccinator signature:	______________________	**V-Safe information given**	□

Leo Lew
Assistant County Manager

Administrative Services

PINAL COUNTY
PUBLIC HEALTH

Louis Andersen
County Manager

Pinal County Public Health Services District

(PCPHSD)

PATIENT RIGHTS

Your individual treatment at this facility will be provided with dignity, respect, and consideration.

1. You have the right to not be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis; to receive treatment that supports and respects your individual choices, strengths, and abilities.

2. Your privacy will be protected. Your examination, treatment and discussions with your clinicians will be kept confidential by the health care providers involved with your care. In addition, all communications and records pertaining to your medical care will be held in strict confidence. You may approve or refuse the release of your medical records to any individual outside the facility, except as otherwise provided by law or third party contract.

3. You have the right to review, upon request, your own medical records.

4. You have the right to participate or have your own representative participate in the development of, or decisions concerning, treatment.

5. You have the right to receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising your patient rights.

6. You will know the identity and professional title of the person(s) providing care for you.

7. You will receive from your clinician, complete and current information regarding the diagnosis, treatment options, alternatives to treatment, and prognosis of your condition in terms that you can understand. You have the right and responsibility to participate in decisions involving your health care.

8. You have the right to refuse treatment and to be informed of the potential consequences of any such action. You have the right to refuse to participate in experimental research and/or treatment.
9. You have the right to expect reasonable continuity of care, within the limitations of available appointment times and clinicians.

10. If it is medically appropriate to refer or transfer you to another health care provider, you will receive complete information and explanation concerning the need for, and alternatives to, such a referral or transfer.

11. You have the right to receive an explanation of any bill coming from the Pinal County Public Health Services District

PATIENT RESPONSIBILITIES

Patients have responsibilities as well as rights. Patients can help themselves by being responsible in the following ways:

1. You are responsible for keeping your appointments at the PCPHSD. If you cannot keep an appointment, it is your responsibility to notify us at least 24 hours ahead so that another client can be seen during that time.

2. You have the responsibility to treat health care professionals with respect and consideration.

3. You are responsible for being honest and direct about anything related to your health care. It is your responsibility to tell your clinician about any changes in your health.

4. You are responsible for understanding your health problems. If you do not understand your illness or treatment, it is your responsibility to ask your clinician about it.

5. It is your responsibility to tell your clinician if you are not able or willing to follow the treatment plan prescribed for you.

6. It is your responsibility to know the names and uses of the medications you are taking.

GRIEVANCE PROCEDURE

You have the right to grieve, formally or informally, any part of the care or treatment you receive at the Pinal County Public Health Services District.

The grievance process steps are:
· Verbal complaint to Clinical Services staff or supervisor.
· Verbal or written complaint directly to PCPHSD at 1-866-960-0633
· If the PCPHSD does not resolve your grievance, you may forwarded to:

Arizona Department of Health Services Public Health Licensing Services
Bureau of Medical Facilities Licensing
150 N. 18th Ave., Suite 450
Phoenix, Az 85007-3245
602.364.3030

I have received a copy of the Pinal County Public Health Services District Clients Rights.

Client's Name_________________________________ Date ______________

Signature _____________________________________