Salem Health Hospitals and Clinics

COVID-19 VACCINE CONDITIONS FOR TREATMENT, CONSENT & SCREENING

Salem Health® Hospitals & Clinics

PATIENT INFORMATION (PLEASE PRINT)

Last Name	**First Name**	**Middle Name**
Race	**Ethnicity**	
Date of Birth	**Phone Number**	**Gender (circle one) M / F / X**

CONDITIONS FOR TREATMENT: The Pfizer and Moderna vaccines are administered as a 2-dose series. The Janssen (J&J) vaccine is a 1-dose vaccine. COMIRNATY (COVID-19 Vaccine, mRNA) is an FDA-approved COVID-19 vaccine made by Pfizer. Comirnaty and Pfizer EUA (Emergency Use Authorization) are recommended for those 12 years and older. For patients that have completed the Pfizer, Moderna series or Janssen dose a booster dose may be administered in eligible populations. The use of each of the available COVID-19 vaccines as a heterologous (or "mix and match") booster dose in eligible individuals following completion of primary vaccination with a different available COVID-19 vaccine. Eligibility for a booster shot:

- If you received a Pfizer or Moderna primary series, at least 6 months has passed and you are 65 years and older, or 18+ living in a long-term care setting, 18+ with underlying medical conditions, or 18+ and live/work in high risk settings, you may have a preference but you can get any booster shot.
- If you received a Janssen (J&J) vaccine as your primary dose, at least 2 months has passed, and you are 18+, you may have a preference but you can get any booster shot.

The Moderna booster dose is half that administered for the primary series dose.

CONSENT: I have received, read, or had explained to me, and understand the COVID-19 vaccine information sheet provided. I hereby authorize Salem Health, its staff or agents to administer the vaccine(s). I understand that the COVID-19 vaccine requires two doses for Pfizer and Moderna and one dose for Janssen to be administered to be considered fully vaccinated. A booster shot to eligible populations will provide additional protection. The scope of this consent includes administration of the vaccines, discussion with a provider if requested, care and treatments immediately after administration, as needed.

ASSIGNMENT OF INSURANCE BENEFITS: I assign to SH the right to receive benefit payments directly from my health insurance or health plan forreimbursement for the administration of the COVID-19 vaccine. I understand that this assignment is final.

#	Screening Questions	Yes	No	Don't Know
1.	Are you feeling sick today?	☐	☐	☐
2.	Have you ever received a dose of a COVID-19 vaccine?	☐	☐	☐
	If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna Janssen ☐ Another Product			
	Have you received a complete COVID-19 vaccine series?	☐	☐	
	Did you bring your vaccine record card or other documentation with you?	☐	☐	
3.	Have you ever had a severe allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
	• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
	• Polysorbate, which is found in some vaccines, film coated tablets and intravenous steroids	☐	☐	☐
	• A previous dose of COVID-19 vaccine	☐	☐	☐
4.	Have you ever had an allergic reaction to another vaccine (other than COVID-19) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	☐
5.	Am a female between ages 18 and 49 years old	☐	☐	☐
6.	Am a male between ages 12 and 29 years old	☐	☐	☐
7.	Have a history of myocarditis or pericarditis	☐	☐	☐
8.	Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies	☐	☐	☐
9.	Had COVID-19 and was treated with monoclonal antibodies or convalescent serum?	☐	☐	☐
10.	Have been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection	☐	☐	☐
11.	Have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
12.	Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
13.	Have a history of heparin-induced thrombocytopenia (HIT)	☐	☐	☐
14.	Am currently pregnant or breastfeeding?	☐	☐	☐
15.	Have dermal fillers?	☐	☐	☐
16.	Have a history of Guillain-Barré Syndrome (GBS)?	☐	☐	☐

Signature of Patient or Authorized Representative: _____ **Date:** _____

Print Patient Name: _____

----------**FOR SITE LOCATION USE ONLY**---------- **FOR DOWNTIME USE ONLY** ----------

MRN _____ **CSN** _____

DOSE #	Site (Circle One)	Route	Manufacturer (Circle One)	Lot #	Vaccine Exp. Date	Administered By & Date/Time (Print Name)
☐ 1 ☐ 2 ☐ 3	LD RD	IM	Pfizer Moderna Moderna booster- ½ dose Janssen			DATE & TIME OF ADMINISTRATION

10-25-21 v.15