COVID 19 CONSENT

Community Health Center of Southeast Kansas

Pfizer	1	2	3	Booster*
Pfizer Pediatric (5-11yrs)	1	2		
Moderna	1	2	3	Booster*
Janssen	1	-	-	Booster*

***Boosters:** Patient's may choose the vaccine they want to receive as a booster. See below for dosing.

PATIENT INFORMATION

Patient's Last Name First Name	Phone Number	Age	DOB

Street Address	City	County	State	Zip Code

Male Female	Primary Care Physician's Name	Hispanic or Latino? Yes No

Race: (Select one or more)
- ❑Native American\Alaska Native
- ❑Asian
- ❑Black or African American
- ❑Native Hawaiian \ Pacific Islander
- ❑Caucasian\White
- ❑Mexican/Puerto Rican
- ❑Other Non-White
- ❑Unknown

Have you had a prior COVID infection? Date: _____ Hospitalized? Yes No
****Are you currently vaccinated for COVID? Yes No Vaccine: _____ Date: _____**
Have you received outpatient infusion with Monoclonal Antibodies? Yes,Date_____ No Unk
Have you received convalescent plasma while treated as an inpatient? Yes , Date_____ No Unk

Please read carefully and answer the following health questions:

1. Is the person to be tested\vaccinated currently sick or have a fever higher than 100.4°F?	Yes	No
2. Has the patient received immunizations in the past 2 weeks? Specify:	Yes	No
3. Does the patient have any allergies to medications, food, vaccine components, or latex?	Yes	No
4. Has the patient had a serious reaction to a vaccine in the past? Specify:	Yes	No
5. Has the patient had health problems with lungs, heart, kidney, or metabolic disease (e.g. diabetes), asthma, or a blood disorder? Is patient on long term aspirin therapy?	Yes	No
6. Has the person to be vaccinated had a seizure or other brain or neurological problems?	Yes	No
7. Does the patient have cancer, leukemia, HIV/AIDS, or other immune system problems?	Yes	No
8. In the last 3 months, has the patient received any treatment that might weaken his or her immune system such as steroids, anti-cancer drugs, chemotherapy, or radiation?	Yes	No
9. In the past 12 months has the patient had a transfusion of blood, blood products, or been given immune globulin? Or has the patient taken any antiviral drugs?	Yes	No
10. Is the patient pregnant, may become pregnant in the next month, or breastfeeding?	Yes	No

MFG	*AGE*	*INTERVAL*	*DOSE*	*EXT*	*SITE*	*ROUTE*	*LOT #*	*EXP DATE*
Moderna	18+	2 doses, 28 days apart 3rd dose >2mo *Booster >6mo	0.5ML 0.5ML 0.25ML	RT LT	Deltoid	IM		
Pfizer	12+	2 doses, 21 days apart 3rd dose >2mo *Booster >6mo	**0.3ML**	RT LT	Deltoid	IM		
Pfizer **Pediatric**	5-11	2 doses, 21 days apart	**0.2ML**	RT LT	Deltoid	IM		
Janssen	18+	1 dose *Booster 2mo+	**0.5ML**	RT LT	Deltoid	IM		

Acknowledgement: The Vaccine Fact Sheet for the above selected vaccine has been made available to me. I have read, had explained to me and understand the information in this statement including the possible adverse reactions, the components of the vaccine, the possible risks, and what to do after the vaccination. I ask the vaccine be given to me or to the person for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below.

_____ _____

Signature of Patient or Parent/Guardian Date CHC/SEK Immunization Provider Date

Revised: 11/2021

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The following is a list of ingredients for the Pfizer-BioNTech, Moderna, and Janssen COVID-19 vaccines reported in the prescribing information for each vaccine.

Description	Pfizer-BioNTech (mRNA)	Moderna (mRNA)	Janssen (viral vector)
Active Ingredient	Nucleoside-modified mRNA encoding the viral spike (S) glycoprotein of SARS-CoV-2	Nucleoside-modified mRNA encoding the viral spike (S) glycoprotein of SARS-CoV-2	Recombinant, replication-incompetent Ad 26 vector, encoding a stabilized variant of the SARS-CoV-2 Spike (S) protein
Inactive Ingredients	2[(polyethylene glucol)-2000]-N, N-ditetradecylacetamide	PEG2000-DMG: 1, 2-dimyristoyl-rac-glycerol, methoxypolyethylene glycol	Polysorbate-80
	1,2-distearoyl-sn-glycero-3-phosphocholine	1,2-distearoyl-sn-glycero-3-phosphocholine	2-hydroxypropyl-β-cyclodextrin
	Cholesterol	Cholesterol	Citric acid monohydrate
	(4-hydroxybutyl)azanediyl)bis(hexane6,1-diyl)bis(2-hexyldecanoate)	SM-102: heptadecane-9-yl 8-((2-hydroxyethyl) (6-oxo-6-(undecyloxy) hexyl) amino) octanoate	Trisodium citrate dihydrate
	Potassium chloride	Tromethamine	Sodium chloride
	Monobasic potassium phosphate	Tromethamine hydrochloride	Sodium hydroxide
	Sodium chloride	Acetic acid	Hydrochloric acid
	Dibasic sodium phosphate dihydrate	Sodium acetate	Ethanol
	Sucrose	Sucrose	Water for injection

Note: None of the vaccines contain eggs, gelatin, latex, or preservatives. Both the Pfizer-BioNTech and Moderna COVID-19 vaccines contain polyethylene glycol (PEG). PEG is a primary ingredient in osmotic laxatives and oral bowel preparations for colonoscopy procedures, an inactive ingredient or excipient in many medications, and is used in a process called "pegylation" to improve the therapeutic activity of some medications (including certain chemotherapeutics). Additionally, cross-reactive hypersensitivity between PEG and polysorbates (included as an excipient in some vaccines and other therapeutic agents) can occur. Information on active or inactive ingredients in vaccines and medications can be found in the package insert. CDC's vaccine excipient summary and the National Institutes of Health DailyMed database can also be used as resources.

Name (Print): _____ Date of Birth: _____/_____/_____

There is no out of pocket cost for the COVID-19 Vaccine:

CHC/SEK will bill commercial insurance for the administration fee of the COVID vaccine only. If insurance denies the claim for any reason, the patient will not be billed. No money is to be collected from any patient regardless of their insurance status. If you are providing a copy of your insurance information, please provide a copy of both the front and back of the insurance card.

Primary Insurance
Insurance Plan _____
Member ID Number_____
Group Number_____
Policy Holder Information
Full Name _____
Date of Birth _____
Social Security Number _____
Relationship to Patient _____
Employer _____

Secondary Insurance
Insurance Plan _____
Member ID Number_____
Group Number_____
Policy Holder Information
Full Name _____
Date of Birth _____
Social Security Number _____
Relationship to Patient _____
Employer _____