THE COUNTY OF CHESTER

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COVID-19 Immunization Screening and Consent Form

Vaccine Recipient Information			
Recipient Name: ***(Please Print)***	**Last**	**First**	**M.I.**
Date of Birth		**Preferred Language**	
Sex Assigned at Birth Male Female Other		**Phone Number**	
Parent/Guardian/ Surrogate (if applicable, please print)		**Email Address**	
Street Address			**Apartment/Unit #**
City		**State**	**Zip Code**

Please Answer the Following Questions by Circling Your Response	
Ethnicity	Non-Hispanic Origin Hispanic Origin Unknown Declined
Race	Asian African American or Black White Other or Multiracial
	Native American or Alaskan Native Hawaiian or Pacific Islander Declined

Screening Questionnaire				
1.	Are you feeling sick today?	☐ Yes	☐ No	☐ Unknown
2.	In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	☐ Yes	☐ No	☐ Unknown
3.	Have you been treated with antibody therapy for COVID-19 or been diagnosed with MIS-A or MIS-C in the past 90 days (3 months)? *If yes, when did you receive the last dose? Date:*	☐ Yes	☐ No	☐ Unknown
4.	Do you carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, foods, vaccines or latex?	☐ Yes	☐ No	☐ Unknown
5.	Are you pregnant or lactating, or considering becoming pregnant?	☐ Yes	☐ No	☐ Unknown
6.	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	☐ Yes	☐ No	☐ Unknown
7.	Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?	☐ Yes	☐ No	☐ Unknown
8.	Have you received a previous dose of any COVID-19 vaccine? *If yes, which manufacturer's vaccine did you receive:*	☐ Yes	☐ No	☐ Unknown
9.	Did you have any allergy symptoms after a COVID-19 vaccine?	☐ Yes	☐ No	☐ Unknown

Please turn over to complete and sign consent form.

Emergency Use Authorization

The U.S. Federal Drug Administration (FDA) has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine generally outweigh the known and potential risks.

Authorization and Consent

CONSENT AND RELEASE: I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be given in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am guardian was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described. I request that the COVID-19 vaccination be given to me (or the person named above for whom I am guardian). I hereby release and forever discharge and hold harmless the County of Chester (hereinafter: County), its officers, employees, agents, and/or assigns from any and all liability, claims, demands, and/or causes of action, either in law or equity, which may hereafter arise from my receipt of the COVID-19 vaccine with respect to any bodily injury (including but not limited to potential allergic reactions and infections) or other injury, including any mental injury, illness, death, or property damage that may result. I understand that the County does not assume any responsibility or obligation to provide financial assistance or other assistance, including, but not limited to medical, health, or disability insurance in the event of injury, illness, death or property damage, unless otherwise expressly governed by and interpreted in accordance the laws of the Commonwealth of Pennsylvania. I agree that in the event that any clause or provision of this Release shall be held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not affect the remaining provisions of this Consent and Release.

Consent for Use of Protected Health Information & Claims Agreement: I hereby consent to and acknowledge the receipt of a Notice of Privacy Practices regarding the use and disclosure of any personal health information for the purpose of health care operations, along with the assignment of all payment from the insurer listed above to VaxCare associated with the services contemplated herein. Vaccine authorization: my signature on this form indicates that I have requested that the vaccine indicated below be administered to me by a VaxCare station or VaxCare representative. I relieve VaxCare, the VaxCare partner, the administering nurse and personnel of any liability for any reactions that should occur. I unconditionally and irrevocably waive any right to a trial by jury, to the maximum extent allowed by law, for any claim or action arising out or related to this service, and that any such claim or action shall be determined solely on an individual basis through arbitration in accordance with Capital Commercial Rules of the American Arbitration Association. Neither I nor VaxCare shall be entitled to join or consolidate claims in arbitration by or against other individuals or entities or arbitrate any claims as a representative member of a class or in a private attorney general capacity. In the case of occupational exposure, VaxCare has permission for blood testing for patient and employee safety alike. I have read or had explained to me the information from the Vaccine Information Statement and understand the risks (including adverse events) and benefits of the vaccine. I understand I will be responsible for payment for the below vaccine, these services are not free, and that nonpayment by the insurance company or patient will result in collections for the amount due. Additionally, I understand that if I am I self-pay or no-pay patient receiving services, that all funds should be paid at the time of the service and not to VaxCare. If consenting for another, I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine administration.

CONSENT AND HIPAA PRIVACY INFORMATION: I have read the above Consent and Release and understand its provisions. I understand that participation in this COVID-19 vaccination program is completely voluntary and not required. I understand the risks and benefits of the vaccine and I request that the vaccine be given to me or the person named above for whom I am the legal guardian. I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries. I hereby freely and voluntarily, without duress, execute this Consent and Release under the above written terms.

Signature *Recipient/Surrogate/Guardian*		**Date:**
Print Name:		**Relationship to Patient** *If other than recipient*

PATIENT DOES NOT COMPLETE THIS SECTION. Area Below to be Completed by Vaccinator

Which vaccine is the patient receiving today?

Vaccine Name	Administration				New Fall 2023	Manufacturer & Lot Number
Pfizer/BioNTech	☐ 1st	☐ 2nd	☐ 3rd	☐ Booster	☐ Yes	
Moderna	☐ 1st	☐ 2nd	☐ 3rd	☐ Booster	☐ Yes	
Novavax	☐ 1st	☐ 2nd				

Administration Site	☐ Left Deltoid	☐ Right Deltoid	☐ Left Thigh	☐ Right Thigh
Dosage	☐ 0.5 mL or ☐ 0.25 mL	☐ 0.3 mL or ☐ 0.2 mL		

	I hereby attest by my signature that the patient (or guardian of patient) in question has been provided access to and explained the Vaccine Information Statement and appropriate immunization schedules and has given verbal and written consent for vaccination.
	I have reviewed side effects with patient (and parent, guardian or surrogate, as applicable)
	I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered correctly and to the best of my ability.

Administrator Signature:		**Date:**	