Covid Vaccine Prevaccination Checklist

Patient Name _____

Birthdate _____

Address_____ Phone Number_____

City, State, Zip_____

	Yes	No	Don't Know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 Vaccine?			
3. Have you ever had an allergic reaction to the following? • A previous dose of COVID-19 vaccine • Polyethylene glycol (PEG)-found in some medications such as laxatives and preparations for colonoscopies • Polysorbate, found in some vaccines, film coated tablets, and intravenous steroids			
4. Have you ever had an allergic reaction to anything at all?			
5. Have you received any vaccines in the past 14 days?			
6. Have you ever been told by your doctor you have COVID-19 and/or tested positive for COVID-19?			
7. Have you ever received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
8. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
9. Do you have a bleeding disorder or are you taking a blood thinner?			
10. Are you pregnant or breastfeeding?			
11. Do you have dermal fillers (usually a facial injection)?			

Medical Professional Reviewing _____ Date_____ L R

HURON COUNTY HEALTH DEPARTMENT

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Mark Hamed, M.D., M.B.A., M.P.H. Medical Director

INFORMED CONSENT

Recipient Name_____

I understand the following:

I will be given a copy of the current federal Emergency Use Authorization (EUA) Fact Sheet for Recipients and Caregivers or the appropriate Vaccine Information Statement (VIS) of the vaccine to prevent COVID-19 that will be administered today.

I will have a chance to ask questions.

I have the right to withdraw my consent to be vaccinated at any point up until the injection.

My health insurance may be billed for the administration fee for the COVID-19 vaccine, but there will be no cost to me.

I will be provided a vaccination record card that I am responsible for.
The administration of the vaccine will be recorded in the Michigan Care Improvement Registry (MCIR).

I authorize the Huron County Health Department (HCHD) to release all pertinent records to my insurance provider for filing and audit purposes for the services provided through HCHD.

_____ _____

Recipient/Parent or Legal Guardian Date