ON SCENE MEDICAL SERVICES

7511 W. Arrowhead Ave., Suite G, Kennewick WA 99336
Clinic: 509-420-5225 | Fax: 509-396-7144
Website: www.OnSceneMed.com

COVID-19 Vaccine Screening and Consent Form
Pfizer-BioNTech COVID-19 Vaccine

SECTION 1: INFORMATION ABOUT YOU (PLEASE PRINT)

Name: Last:	**First:**	**Middle Initial:**
Date of Birth:	**Sex**(gender assigned at birth) ☐ Female ☐ Male	**Mobile Phone No (Patient or Guardian):**

Race:
☐ American Indian or Alaskan Native ☐ Native Hawaiian or Other ☐ Other Asian ☐ Other
☐ Asian ☐ Pacific Islander ☐ Other Nonwhite
☐ Black or African American ☐ White ☐ Other Pacific Islander

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Address: **Apt/Room #**

City: **State:** **Zip:**

Primary Insurance Carrier ID # _____ Grp #_____

Insurance Company:_____ Insurance Company Phone #_____

Insured's Name:_____ Relationship:_____ Insured's Date of Birth:_____

Secondary Insurance Carrier ID # _____ Grp #_____

Insurance Company:_____ Insurance Company Phone # _____

Insured's Name:_____ Relationship:_____ Insured's Date of Birth:_____

Is this the patient's first or second dose if the COVID-19 vaccination? ☐ First Dose ☐ Second Dose

SECTION 2: COVID-19 SCREENING QUESTIONS

Please check YES or NO for each question.	Yes	No
1. Are you sick today?		
2. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
3. Do you carry an Epi-pen for emergency treatment of anaphylaxis?		
4. For women, are you pregnant or is there a chance you could become pregnant?		
5. For women, are you breastfeeding?		
6. Have you had any other vaccinations in the previous 14 days?		
7. In the past two weeks, have you tested positive for COVID-19		
8. Have you had in the last 10 days fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting or diarrhea?		

SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE

Please check Yes or NO for each question	Yes	No
9. Do you have allergies or reactions to any medication, foods, vaccines, or latex? Please explain:		
10. Are you immunocompromised or on a medicine that affects your immune system?		
11. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
12. Have you received a previous dose of any COVID-19 Vaccine? If yes, which manufacturer's vaccine did you receive:		

ON SCENE MEDICAL SERVICES

7511 W. Arrowhead Ave., Suite G, Kennewick WA 99336
Clinic: 509-420-5225 | Fax: 509-396-7144
Website: www.OnSceneMed.com

- I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 18 years if age; or (c) authorized to consent for vaccination for the patient names above. Further, I hereby give my consent to On Scene Medical Services, P.C. and their affiliated entities, their agents, owners, officers, employees, and representatives to administer the COVID-19 vaccine.
- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 16 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read, and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- I acknowledge that I have been advised to remain new the vaccination location for approximately 15 minutes after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs, and personal representatives, I hereby release and hold harmless On Scene Medical Services, P.C. and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors, and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.
- I acknowledge that this vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting by On Scene Medical Services, P.C. to an immunization registry, which may share my immunization data with the local Department of Health, if applicable, and I authorize these disclosures.
- I further authorize On Scene Medical Services, P.C. or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the about requested items or services. I assign and request payment of authorized benefits be made on my behalf to On Scene Medical Services, P.C. or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if On Scene Medical Services, P.C. invoices me after the time of service, upon receipt of such invoice.
- I acknowledge receipt of the Notice of Privacy Rights.

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

Print Name of Representative and Relationship to Person Receiving Vaccine:_____

Date of Vaccination: _____ **Administered by**: _____

Manufacturer: **Pfizer** Type: **COVID-19** Lot # **ER8732** Expiration Date: **07/2021**

Dose: **0.5 mL** Site: ☐ Right Deltoid ☐ Left Deltoid