The Villages Health
Stay healthy. Heal quickly.

Please complete the following information in preparation for your COVID-19 Vaccine and bring with you to your appointment.

Last Name:

_____

First Name:

_____

Date of Birth: (mm/dd/yyyy)

_____

Sex: ☐ Male ☐ Female

Street Address (must be in FL):

_____

City: _____

State:_____

Zipcode_____

Florida County of Residence:

☐ Lake ☐ Marion ☐ Sumter ☐ Alachua
☐ Citrus ☐ Orange ☐ Pasco ☐ Polk
☐ Seminole ☐ Volusia ☐ Other

Area Code and Phone Number:

( ) _____

Ethnicity:

☐ Hispanic or Haitian origin
☐ Not Hispanic/Haitian origin

Race:

☐ White ☐ Black/African American ☐ Asian ☐ Other

Email: _____

**notifications including appointment confirmation will be sent to this email

Insurance Carrier:

_____

Policy No._____Group # _____

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Thank you for your interest in the COVID Vaccine. Answering the following questions will help us determine if there is any reason you should not get the COVID-19 vaccine at this time. These questions will help us better understand your patient profile and if you need to delay your vaccination (i.e. because you have recently had another vaccine) and/or receive a medical clearance form their primary care doctor in order to proceed with vaccination at a care center. If you are not eligible to schedule your vaccination at this time, you may be eligible to schedule your vaccination at a later date.

Please Check 'Yes' 'No' in Response to the following questions as it relates to your health:

	Yes	No
1. Do you have today or have you any time in the last 10 days a 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?		
2. Have you ever had an 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 a COVID-19 vaccine including either of the following:		
○ 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.		
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.		
3. Have you received any vaccine in the last 14 days?		
4. Have you had a positive test for COVID-19 or has a doctor told you that you had COVID-19 in the last 14 days?		
5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 in the past 90 days?		
6. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) 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.)		
7. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.		
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?		
12. Have you ever received a dose of COVID-19 vaccine?		

If yes, which vaccine product did you receive?

□ Pfizer □ Moderna □ Janssen (Johnson & Johnson) □ Another product name:_____

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Covid-19 Vaccine Consent

By signing to submit my vaccination below request, I certify that:

- I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the patient and confirm that the patient is at least 18 years of age; or (c) legally authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to The Villages or its agents 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 either 16 years of age or older or 18 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 will need to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after the administration of my vaccination 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 The Villages Health, The Villages, the State of Florida, the Florida Department of Health (DOH), the Florida Division of Emergency Management (FDEM), 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: (a) I understand the purposes/benefits of Florida SHOTS, Florida's immunization registry, and (b) DOH will include my personal immunization information in Florida SHOTS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize The Villages Health, DOH, FDEM, or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above-requested items and services if/as applicable. I assign and request payment of authorized benefits be made on my behalf to The Villages or its agents with respect to the above-requested items and services.

And I consent to receive my vaccine: ☐ Yes ☐ No

_____ _____
Patient Signature Date

_____ _____
Parent/Legal Guardian Signature Date

Thank you. This Completes the Survey