COVID-19 VACCINATION-STUDENT CONSENT & SCREENING FORM

VDH VIRGINIA DEPARTMENT OF HEALTH
To protect the health and promote the well-being of all people in Virginia.

Name: _____
Last First Middle

Date of Birth: ____/____/____ **Age:** ____ **Gender:** ☐M ☐F **Hispanic/Latino** ☐Yes ☐No

Race: ☐American Indian/Alaskan Native ☐Asian ☐Black or African American ☐Hawaiian Native or Other Pacific Islander ☐White ☐Not Stated

If minor - parent/guardian's name & date of birth _____ _____
Last First M.I. Date of birth mm/dd/yyyy

Address: _____ City/State: _____ ZIP: _____

Grade: _____ **Home Room Teacher:** _____ **School:** _____

IMPORTANT Parent/Guardian Phone # Home: _____ Cell: _____ Work: _____

Insurance Type: ☐ Private Ins ☐ Medicaid/medical assistance ☐ Medicare ☐ No Insurance

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any VDH health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.
2. If you should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the tests.

I have read the Emergency Use Authorization Fact Sheet for the COVID-19 vaccine and understand the risks and benefits. I believe the benefits outweigh the risks, and I accept full responsibility for any reactions that may result from the receipt of the immunization. I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the COVID-19 vaccine.

Office of Privacy and Security - Authorization for Disclosure of Protected Health Information

This consent gives the Virginia Department of Health (VDH) permission to disclose personal health information to the person(s) or organization(s) I have indicated.

- I understand the provision of treatment to my child cannot be conditioned on my signing of this authorization.
- Any health information redisclosed by me or my child will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included with my child's medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize VDH to disclose my child's health information to his/her primary care physician and school.
- I understand that this record will be retained until my child reaches 21 years of age.
- I authorize VDH release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. The third party payer to pay any authorized benefits to VDH on my behalf.
- I understand this document will be given to and retained by the public health department and will not be maintained by the school.

☐ Please check box if you wish to receive a copy of the Virginia Department of Health Privacy Rights

X _____
Patient, Parent/Legal Guardian, Person Acting in Loco Parentis-Printed Name Signature Date

PARENTS – PLEASE COMPLETE THE SCREENING QUESTIONNAIRE ON BACK

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OFFICE USE ONLY				
Vaccine	**Lot Number**	**Route**	**Admin. Site**	**Provider/#**
COVID-19-PFR Vaccine **Pfizer** (0.3 mL) #1 #2		IM	☐ RA ☐ LA	
COVID-19-MOD Vaccine **Moderna** (0.5 mL) #1 #2		IM	☐ RA ☐ LA	
Provider Printed Name:	**Signature:**		**Date:**	

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Name _____

Age _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.
If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked.
If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. 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 _____			
3. 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.	☐	☐	☐
4. 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.)	☐	☐	☐
5. 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.	☐	☐	☐
6. Have you received any vaccine in the last 14 days?	☐	☐	☐
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
10. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
11. Do you have a history of or a risk factor for a blood clotting disorder?	☐	☐	☐
12. Are you pregnant or breastfeeding?	☐	☐	☐
13. Do you have dermal fillers?	☐	☐	☐

Form reviewed by _____ **Date** _____