FAIRFIELD MEMORIAL HOSPITAL
Fairfield, Illinois

COVID VACCINE CONSENT AND SCREENING FORM

Name: _____ Sex: ☐ M ☐ F

Department: _____ Date of Birth: _____ Age: _____

Home Address: _____

City, State, Zip: _____ Home Phone Number: _____

Race: ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Other race ☐ Unknown

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

Please answer the following questions:

COVID-19 SCREENING QUESTIONS	Yes	No
1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?		
2. In the past two weeks, have you had contact with anyone who tested positive for COVID-19?		
3. Have you had the new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?		

IMMUNIZATION SCREENING QUESTIONS	Yes	No
1. Have you ever had a serious reaction after receiving a vaccination? Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?		
2. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?		
3. For women, are you pregnant or is there a chance you could become pregnant during the next month?		
4. Have you received any vaccinations or TB skin test in the past 4 weeks?		

To be completed by Nurse:

Complete **DURING** the patient interaction:

1. I have asked the patient to confirm their Name, DOB, and Requested Vaccine and verified it matches the information on the top of this consent. _____Nurse Initials
2. I have reviewed the Screening Questions with the patient. _____Nurse Initials
3. I have the reviewed the VIS with the patient. _____Nurse Initials

Patient Name: _____ DOB: _____

I have received and read the COVID Vaccine Statement (VIS) and have had the chance to ask questions which were answered to my satisfaction. I understand the benefits and risk of the vaccine. VIS Title: **COVID Vaccine Statement (VIS)**

I consent to have my vaccination added to the Illinois State Registry and to my Electronic Health Record.

Signature of Patient: _____ Date: _____

Complete **AFTER** vaccine administration:

Name/Manufacturer & Lot #: _____

Exp. Date: _____ ☐ Initial Dose ☐ Second Dose

Vaccine	NDC	Manufacturer	Dosage	Site of Administration	VIS published date

If initial dose, date second dose is to be administered: _____

Card given to patient with next due date ☐ Yes ☐ No

Clinician's name (print): _____ Title: _____

Clinician's signature: _____ Date: _____

Administration date: _____ Date VIS given to patient: _____

Notes:

_____

_____

_____

Reminder:

1. Update the patient's record with any new allergy, health condition, or primary care provider information.
2. Enter vaccine lot #, expiration date, and site of administration.
3. Enter into the I-CARE registry.

(2-8-2021)