Seven Hills Behavioral Health

Vaccine Administration Record- Informed Consent for Vaccination
(For use with COVID-19 Vaccine Administration Clinic)

For office use only:
_____

Patient Information

Name: _____ **Date of Birth**: ____/____/____

Address: _____
STREET CITY ZIPCODE

Phone Number: _____ **Email Address**: _____

Gender Identity: ☐Male ☐Female ☐Transgender ☐Nonbinary ☐Questioning ☐Other

Primary Language: _____ **Country of Birth**: _____

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

Hispanic/Latinx: ☐Yes ☐No ☐Don't Know

Insurance: ☐Masshealth ☐Medicare ☐Health Safety Net ☐Private ☐Other ☐No Insurance

Do you have a Primary Care Provider: ☐Yes ☐No ☐Don't Know

I want to receive the following vaccine:

1st, 2nd, or 3rd dose:
- ☐ Janssen/Johnson & Johnson
- ☐ Moderna (ages 12+)
- ☐ Pfizer (ages 12+)
- ☐ Pediatric Pfizer (ages 5-11)

Booster dose:
- ☐ Moderna Bivalent (ages 18+)
- ☐ Pfizer Bivalent (ages 12+)
- ☐ Pediatric Pfizer (ages 5-11)

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; (c) the legal guardian of the patient.

1. I certify that the information I have provided is correct and that I have the legal authority to give consent for me and any other person(s) I registered to be vaccinated with the vaccine(s) above.
2. I hereby give my consent to Seven Hills Behavioral Health, the Seven Hills Behavioral Health staff, New Bedford Emergency Medical Services, and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable provider"), to administer the vaccine(s) I have requested above.
3. 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 Fact Sheet for Recipients and Caregivers" on the vaccine(s) 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.

4. I acknowledge that I have been advised to remain near the vaccination location for observation for approximately 15 minutes after administration.
5. On behalf of myself, my heirs and personal representatives, I hereby release and hold 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(s) listed above.
6. I give permission for my insurance company to be billed for the costs of administering the vaccine(s). The government is paying for the vaccine itself and I will not be billed for that portion of the cost of my immunization.
7. I understand that, as required by state law, all immunizations will be reported to the Department of Public Health Massachusetts Immunization Information System (MIIS). MIIS is a confidential, web-based system that collects and stores vaccination (shot) records accessible to healthcare providers and local boards of health. I consent to having my vaccination information entered into MIIS. I understand I may access the MIIS factsheet for Parents and Patients, at www.mass.gov/dph/miis, for information on the MIIS and what to do if I object to my or my family's data being shared with other providers in the MIIS.

Patient Signature: _____ **Date:** _____

(Parent or guardian, if minor)

DO NOT WRITE BELOW THIS LINE

FOR STAFF USE ONLY

Dose being received (check one): ☐ **1st Dose** ☐ **2nd Dose** ☐ **3rd Dose (immune compromised)** ☐ **Booster**

Date of Service	Vaccine Type	Vaccine Mfg.	Lot #	Mfg. Date	Dose (ml)	State Supplied	Injection Route	Injection Site	Date EUA given
	COVID-19					MA	IM	R arm L arm	

Signature of Vaccine Administrator: _____ **Date:** _____

Prevaccination Checklist for COVID-19 Vaccination

Name _____

For vaccine recipients (both children and adults):

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

	Yes	No	Don't know
1. How old is the person to be vaccinated? _____			
2. Is the person to be vaccinated sick today?	☐	☐	☐
3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product was administered? ☐ Pfizer-BioNTech ☐ Janssen *(Johnson & Johnson)* ☐ Another Product ☐ Moderna ☐ Novavax _____			
• How many doses of COVID-19 vaccine were administered? _____			
• Did you bring the vaccination record card or other documentation?	☐	☐	
4. Is the person to be vaccinated have a health condition or undergoing treatment that makes them moderately or severely immunocompromised? *This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.*	☐	☐	☐
5. Is the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
6. Has the person to be vaccinated 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 caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. Has the person to be vaccinated 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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

8. Check all that apply to the person to be vaccinated:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a history of Guillain-Barré Syndrome (GBS)
- ☐ Have a history of COVID-19 disease within the past 3 months?

Form reviewed by _____ **Date** _____