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Kuraoka Clinic

COVID-19 Vaccine Questionnaire & Consent Form

Please Print Information for Person Receiving Vaccine				
Last Name	First Name	DOB (mm/dd/yyyy)	Age	Gender ☐M ☐F
Street Address			State	Zip
E-Mail Address			Phone Number	
Race ☐ African American ☐ Asian ☐ American Indian/Alaska Native ☐ White ☐ Native Hawaiian/ Pacific islander ☐ Hispanic/ Latino ☐ Other			Ethnicity ☐ Hispanic ☐ Non- Hispanic ☐ Unknown	

Medical Insurance	Member ID #	Group ID#	Policy Holder Name	Policy Holder DOB

***If uninsured, you must initial the box below to attest that the following information is true and accurate**

☐ I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government-funded health benefit plan.

Initial

In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, please provide valid Social Security number. *SSN _____

	COVID-19 Vaccine Screening Questions	YES	NO
1.	Have you ever received a COVID-19 vaccine before? If Yes, date vaccine received: _____and vaccine manufacture:_____	☐	☐
2.	Are you feeling sick today?	☐	☐
3.	Are you currently under isolation (infected with COVID-19) or under quarantine (exposed to someone with COVID-19)?	☐	☐
4.	Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days?	☐	☐
5.	Do you have any allergies to any vaccine, component of vaccines, polyethylene glycol, and/or do you have a prescription for an Epinephrine pen for severe allergic reactions?	☐	☐
6.	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	☐	☐
7.	Do you have bleeding disorder or are you on a blood thinner medication?	☐	☐

CONSENT FOR SERVICES: I have been provided with the FDA-issued EUA fact sheet corresponding to the vaccine that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: contact doctor, call 911, fill out in V-Safe. I request that the vaccine be given to me.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize Kuraoka Clinic to release information and request payment. I certify that the information given by me in applying for payment under Commercial Insurances, Medicare/Medicaid, or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

EMERGENCY USE AUTHORIZATION (EUA): The FDA has made the COVID-19 vaccine available under an emergency use authorization. The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

X

Print Name (患者名) Signature Date

For the guardian or authorized representative of the patient receiving the Pfizer Vaccine,

I GIVE CONSENT for the child named at the top of this form to get vaccinated with the Pfizer- BioNTech COVID-19 Vaccine and have reviewed and agree to the information included in this form.

X

Name of guardian, or authorized representative(保護者名) Signature Relationship Date

Vaccine Administration Information/ Kuraoka Clinic use only

Vaccine/Manufacture/ Lot# / Exp.	Dose	Route	Site	Administered By
	0.5ml 0.2ml 0.3ml 0.25ml	Intramuscular	Deltoid ○L ○R	