



STATE OF MISSOURI
 BUREAU OF IMMUNIZATIONS (adapted by Kilgore's Medical Pharmacy)
COVID-19 VACCINATION SCREENING AND CONSENT UNDER EMERGENCY USE
AUTHORIZATION

Please complete the following information for the person receiving the COVID-19 vaccine.

PATIENT DEMOGRAPHIC INFORMATION					
LAST NAME			FIRST NAME		MIDDLE INITIAL
DATE OF BIRTH		ARE YOU A MINOR LESS THAN 18 YRS OLD <input type="checkbox"/> Yes <input type="checkbox"/> No		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other	
RACE <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> None Specified <input type="checkbox"/> Refused			HISPANIC ETHNICITY <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Refused		DO YOU HAVE A DISABILITY? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to answer
ADDRESS			CITY		
STATE	ZIP	COUNTY	HOME PHONE		CELL PHONE
EMAIL					

Private or employer insurance
 Underinsured
 Uninsured
 Medicare
 Medicaid

HEALTH HISTORY		YES	NO	UNKNOWN
1.	Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have you ever received a dose of COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	If yes, which vaccine product did you receive? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (J&J) <input type="checkbox"/> Other Product Date Received _____			
4.	In the past 14 days have you had contact with a confirmed COVID-19 patient?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	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.) <ul style="list-style-type: none"> • 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 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Have you been diagnosed with an immune mediated syndrome characterized by thrombosis and thrombocytopenia or Heparin Induced Thrombocytopenia (HIT)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Do you have dermal fillers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Are you pregnant or breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Do you have or have a history of Multisystem Inflammatory Syndrome in Children or Adults (MIS-C or MIS-A)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICP to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The CICP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use of the covered countermeasures identified in the PREP Act declaration. The PREP Act declaration for medical countermeasures against

COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV-2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any product. Information about the CICIP and filing a claim is available by calling 1-855-266-2427 or visiting <https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine> <https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/moderna-covid-19-vaccine> <https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/janssen-covid-19-vaccine>

MINOR SELECTION OPTIONS (DOCUMENTATION REQUIRED UNLESS PARENT/GUARDIAN PRESENT)

<input type="checkbox"/> With Parent/Guardian	<input type="checkbox"/> With Parent/Guardian Consent	<input type="checkbox"/> Relative Caregiver	<input type="checkbox"/> Children's Division
<input type="checkbox"/> Married	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Minor Parent	<input type="checkbox"/> Homeless Youth

PLEASE PRINT NAME of signature below

SIGNATURE OF PATIENT	RELATIONSHIP TO CLIENT	TODAY'S DATE
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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge and agree that I have received or have been advised of Kilgore's Medical Pharmacy's Notice of Privacy Practices and where I can obtain any revisions made to this Notice.

PRINT NAME HERE

CLIENT SIGNATURE/LEGAL REPRESENTATIVE	RELATIONSHIP TO CLIENT	TODAY'S DATE
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FOR CLINIC USE ONLY

MANUFACTURER	BRAND	LOT NUMBER
DOSE NUMBER <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	*EXP. DATE	*DATE ADMINISTERED
*EUA FACT SHEET DATE	*EUA FACT SHEET GIVEN DATE	INJECTION SITE (DELTOID) <input type="checkbox"/> L <input type="checkbox"/> R

DOCUMENTATION REQUIRED BY MINOR

Yes No

A minor under the care of a parent/guardian that physically appears and signs the requisite paperwork for the minor to receive the vaccination.

Notarized written consent in cases where the Parent/Guardian is not present at the vaccination.

Un-notarized written consent, if verbal confirmation can be obtained by telephone, in cases where the Parent/Guardian are not present at the vaccination.

A minor under the care of a relative caregiver. The affidavit as explained in §431.058, RSMo, must be provided for the minor to receive the vaccination.

A minor under the care of the Department of Social Services, written consent from Children's Division (or designee) or Division of Youth Services must be provided for the minor to receive the vaccination.

A minor married, pregnant, or minor parent, under §431.061, RSMo (minor parent, married minor, etc.) Documentation shown at time of vaccine: _____

"Homeless youth" (qualified youth) as provided in §431.056, RSMo, such documentation may be letters from persons/entities such as (but not limited to): a director or designee of a governmental or nonprofit agency that receives public or private funding to provide services to homeless persons; a location education agency liaison for homeless children and youth designated under 42 U.S.C. Section 11432(g)(1)(J)(ii); a school social worker/counselor; or a licensed attorney representing the minor in any legal matter.

Procedural note: Copies, duplications, or reproductions of certified copies of vital records are prohibited by state law. If a vital record is provided to fulfill the minor documentation requirement, review document to confirm eligibility, and then return to patient. Other minor documentation should be copied. Original versions of affidavits or written consent forms should be retained.

VACCINE DOSE

ADMINISTERED BY NAME & TITLE

AGENCY
Kilgore's Medical Pharmacy

AGENCY ADDRESS
700 N Providence Road Columbia, MO 65203

CLINIC ADMINISTRATION ADDRESS (if blank, same as agency address)