

COVID-19 VACCINATION-STUDENT CONSENT & SCREENING FORM



Name:	Last		First			Midd	lle				
Date of Birth:	/ /	_ Age: _		Gender:	$\square M$	□F H	ispanic/Latino	\square Yes	\square No		
Race: □American India	an/Alaskan Native	\square Asian	□Black	or African	America	n □Ha	waiian Native or	Other Pac	cific Islander		
□White □Not Stated											
If minor - parent/guard	ian's name & da	te of birth	Last		First		M.I.	Date of b	irth mm/dd/yyyy		
Address:											
			City/State:ZIP:								
IMPORTANT Parent/Guardian Phone # Home:				Cel							
Insurance Type: □ Pa											
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											
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Prevaccination Checklist for COVID-19 Vaccines



For vaccine recipients:	Patient Name			
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 mea should not be vaccinated. It just means additional questions may If a question is not clear, please ask your healthcare provider to expl	oe asked.	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 &	hnson) 🔲 Another prod	duct		
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required would also include an allergic reaction that occurred within 4 hours that cause				nospital. It
A component of a COVID-19 vaccine including either of the	following:			
 Polyethylene glycol (PEG), which is found in some medical preparations for colonoscopy procedures 	ions, such as laxatives and			
O Polysorbate, which is found in some vaccines, film coated	ids.			
A previous dose of COVID-19 vaccine.				
A vaccine or injectable therapy that contains multiple comp vaccine component, but it is not known which component e				
4. Have you ever had an allergic reaction to another vaccine (oth injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required caused you to go to the hospital. It would also include an allergic reaction that swelling, or respiratory distress, including wheezing.)	reatment with epinephrine or EpiPer	n® or that		
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) of COVID-19 vaccine, or any vaccine or injectable medication? 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 ev	er told you that you had COVID	-19?		
8. Have you received passive antibody therapy (monoclonal antil treatment for COVID-19?	oodies or convalescent serum) as		
9. Do you have a weakened immune system caused by something you take immunosuppressive drugs or therapies?	such as HIV infection or cance	r or do		
10. Do you have a bleeding disorder or are you taking a blood thin	ner?			
11. Are you pregnant or breastfeeding?				
12. Do you have dermal fillers?				