STATE OF MISSOURI
BUREAU OF IMMUNIZATIONS

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: SOCIAL SECURITY NUMBER:	SEX: ☐ Male ☐ Female ☐ Transgender ☐ Other	

RACE:
☐ White ☐ Black ☐ Asian ☐ Pacific Islander
☐ American Indian/Alaskan Native ☐ None Specified ☐ Refused

HISPANIC ETHNICITY:
☐ Yes ☐ No
☐ Unknown ☐ Refused

ADDRESS:	CITY: COUNTY:

STATE:	ZIP:	HOME PHONE:	CELL PHONE:

EMAIL ADDRESS:

Phase 1A - Patient-Facing Health Care Workers and Long-Term Care Facility Residents and Staff: Vaccinating those most vulnerable and those protecting them

- ☐ Hospitals, Long-term care facilities and residents, including Department of Mental Health
- ☐ Home health, Hospice, Dialysis centers, Urgent care
- ☐ Vaccinator staff and those administering COVID testing
- ☐ Congregate community healthcare settings staff and residents, including DMH contracted settings and adult day cares
- ☐ EMS and high-risk non-congregate healthcare, including clinics, physicians, and home care providers
- ☐ All remaining patient-facing healthcare providers, including but not limited to health care workers in emergency shelters, dental offices, school nurses, pharmacies, public health clinics, mental/behavioral health providers, and correctional settings

Phase 1B - Tier 1 Worker Information: Protecting those who keep us safe and help during emergencies

☐ First Responders ☐ Non-Patient Facing Public Health Infrastructure ☐ Emergency Management and Public Works
☐ Emergency Services Sector

Phase 1B - Tier 2 High-Risk Individuals: Protecting those who are at increased risk for severe illness

- ☐ Anyone aged 65 and older
- ☐ Any Adult with the following conditions:

  Cancer, Chronic Kidney Disease, COPD (chronic obstructive pulmonary disease), Intellectual and/or developmental disabilities such as Down Syndrome, Heart Conditions (such as heart failure, coronary artery disease, or cardiomyopathies), Immunocompromised state from solid organ transplant, Severe Obesity (BMI greater than 40), Pregnancy, Sickle Cell Disease, &/or Type 2 Diabetes Mellitus

Phase 1B - Tier 3 Critical Infrastructure: Protecting those who keep the essential functions of society running

☐ Education (K-12) ☐ Childcare ☐ Communications Sector ☐ Dams Sector ☐ Energy Sector
☐ Information Technology Sector ☐ Nuclear Reactors, Materials, and Waste Sector
☐ Transportation Systems Sector ☐ Water and Wastewater Systems Sector

- ☐ Government: Certain elected/appointed officials or other personnel designated by the executive, legislative, and judicial branches of state government
- ☐ Food/Agriculture Sector – initial: Employees of certain food production and processing facilities, and related operations, prioritizing mass food production, distribution, transportation, wholesale, veterinary serves, and retail sales.

Phase 2, Equity & Economic Recovery: Protecting those who have been disproportionately affected and accelerating economic recovery

☐ Chemical Sector ☐ Commercial Facilities Sector ☐ Critical Manufacturing Sector ☐ Defense Industrial Base Sector
☐ Financial Services Sector ☐ Higher Education ☐ Disproportionately Affected ☐ Homeless

- ☐ Government: Other state and local government designated personnel required to provide essential services
- ☐ Food/Agriculture Sector II: Remaining populations within the sector not included in 1B, including restaurants

Phase 3, Remaining Unvaccinated Populations: Protecting everyone else who has not been vaccinated, but wants to do so

- ☐ Resident who doesn't fall into the above phases/tiers

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge and agree that I have received or have been advised of the Missouri Department of Health and Senior Services' 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

HEALTH HISTORY	YES	NO	UNKNOWN
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something?	☐	☐	☐
For example, a reaction for which you were treated with epinephrine or Epi Pen or for which you had to go to the hospital?	☐	☐	☐
3. Have you ever had a serious reaction after any vaccination or injectable medication including a previous dose of the COVID-19 vaccine?	☐	☐	☐
4. In the past 14 days have you had contact with a confirmed COVID-19 patient?	☐	☐	☐
5. Are you breastfeeding or pregnant?	☐	☐	☐
6. Have you received passive antibody therapy as a treatment for COVID-19?	☐	☐	☐
7. Are you immunocompromised? *(taking medication or being treated for cancer, leukemia, HIV/AIDS or other immune system problems or taking medication that affects your immune system)*	☐	☐	☐
8. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
9. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
If so, Date received _____			

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 covered countermeasures identified in a 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 such product. Information about the CICP 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 or https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/moderna-covid-19-vaccine

The State of Missouri is conducting a phased roll-out of the COVID-19 vaccine prioritizing saving lives and is dictated by vaccine availability. This form will gather information about you, including your employment and health risks to determine your eligibility and properly schedule your vaccination appointment. All your information will be kept confidential to the extent allowed by law. **By signing below you are self-certifying that everything you have indicated on this form is true and that you fall into the phase/tier indicated above.**

Specific information about the populations within each phase/tiers can be found on the MOStopsCovid.com website.

SIGNATURE/GUARDIAN	RELATIONSHIP TO CLIENT	TODAY'S DATE

Insurance Information: Required

Self Pay: Y or N

Insurance Name: _____

Policy #: _____ Group #: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Subscriber Name: _____ DOB: _____

Subscriber Social:

For Clinic Use only

Manufacturer	**Brand**	**Lot number**
Dose number 1☐ or 2☐	***Exp. Date:** ___ /___ /___	***Date Administered:** ____ /____ /___
***EUA fact sheet date:** ___ /___ /___	***EUA fact sheet given date:** ___ /___ /___	**Injection Site (Deltoid) L ☐ R ☐** **Vaccine Dose** _____
***Administered by Name & Title :**		
***Agency: Phelps Health**		
***Agency Address 1000 W. 10th St, Rolla MO 65401**		
***Clinic administration address**		